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ABSTRACT

Rehabilitation counselors must stay apprised of numerous issues in their field. To help them remain current, this volume features 12 lessons which can count as continuing education credits. Lesson 1 explores issues surrounding Latino clients, focusing on cultural considerations, ethnic identity, and the counselor-client relationship. Sexuality issues in clients with physical disabilities are discussed in lesson 2, with a focus on developmental issues and psychological considerations. Counseling women in mid-life, which features an integrative approach to menopause, and ways to utilize community resources in rehabilitative counseling are covered in lessons 3 and 4. Lesson 5 provides counseling strategies when working with Native Americans, whereas lesson 6 explores ways to provide vocational services to clients in substance abuse rehabilitation. The treatment of comorbid posttraumatic stress disorder and substance abuse is addressed in lesson 7 and lesson 8 features tips on program evaluation and assessment of outcomes. Lesson 9 describes issues surrounding mood disorders following traumatic brain injury and lesson 10 discusses interventions and rehabilitation counseling for autistic clients and their families. The last two lessons center on life care planning and how to prepare for cross-examination as an expert witness. Each lesson contains references and questions. (RJM)

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Directions in Rehabilitation Counseling

Volume 9 Lesson 1

Counseling Latino Clients: Cultural Considerations for Rehabilitation Counselors

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Background

Latinos currently constitute more than 10% of the total U.S. population and are the fastest growing ethnic minority.[1] The term Latino will be used throughout this article, although the term Hispanic is used by the United States Bureau of the Census. The latter may be restricted to the use of the Spanish language whereas Latino appears to be more inclusive of broader cultural commonalities.[2] Of the various Latino groups, Mexican Americans are the largest, followed by Central and South Americans and Cubans.[2] Latinos live in all parts of the United States, although 87% are located in 10 states: California, Texas, New York, Florida, New Jersey, Arizona, New Mexico, Colorado, Massachusetts, and Illinois. As a group, Latinos are heterogeneous, reflecting diverse cultures, languages, generational patterns, and mores. If projections about Latino growth patterns at the turn of the century are accurate, a "typical" Latino likely will be a 40-year-old married Mexican-American living in an urban area in a household with 3–5 people who speak Spanish at home. This person will likely have a high school education, a job in labor or service, and a median family income of about $23,000.

Approximately 15% of the Latino population in the United States will have a disability. This compares to about 20% for non-Latino whites, 20% for African-Americans, and 10% for Asian-Americans.[3] This rate of disability may be increasing faster than that of any other group. Bowe reports a disability growth rate of about 30% among Latinos, which is five times higher than the rate for other racial ethnic groups.[4] The employment picture for people with disabilities, and for Latinos with a disability in particular, is bleak. Latinos, both male and female, with disabili-

ties have high rates of unemployment: 72% for males and 81% for females.[5] This compares to 61% and 71% respectively for non-Latino white males and females with disabilities. For the most part, Latino males with disabilities hold labor-type occupations (32%) and females, service or clerical occupations (32% and 29%). The mean earnings for Latinos show a substantial drop following a disability, to about $12,000 for males and $8,000 for females.

Insurance coverage in the United States is most often associated with employment. Because Latinos with disabilities have a higher rate of unemployment, their access to insurance is limited. Even among Latinos without disabilities, employment situations are often tenuous and underpaid, with employers who do not provide insurance.[6] Mexican-Americans as a whole are the group least likely to be covered by insurance.

Educational levels for Latinos with a disability are similar to those of the total Latino population without a disability. However, only about 7% of Latinos with a disability graduate from college, compared to 14% of Latinos without a disability.[4] This poses a significant challenge for rehabilitation counselors who need to provide retraining services to Latinos with disabilities who may lack adequate transferrable skills.

Latinos are similar to the total U.S. population in types of disability.[7-12] In terms of physical disabilities, there are two diseases that are more prevalent among Latinos; these are cancer and diabetes mellitus, which are chronic and usually require rehabilitation. The risk of AIDS is three times higher for Latino males than for white males.[7] This is a condition that, given the new medications available today, is becoming a chronic disability requiring vocational rehabilitation. **In terms of mental disorders, the most frequently reported problems are substance abuse and learning disabilities.** Both of these mental disorders are costly for society and for the individual.

Bowe reports that a typical Latino with a disability is 43-years-old, married, lives in an urban area, and has a high school diploma.[4] This person's disability is likely to be severe and he or she is likely to be unemployed. The most likely occupation would be a blue collar job with an income of about $11,000. From the standpoint of rehabilitation services, Latinos are not likely to be obtaining the full benefit of vocational rehabilitation. They are frequently found to be ineligible for services and less money is spent on their rehabilitation. This could explain the poor employment outcomes for Latinos with disabilities as compared to other groups.[3]

This lesson will focus on Latinos with disabilities, and where possible will identify the specific Latino group involved, (e.g., Mexican American). For simplicity, we have chosen to focus on substance abuse because of its prevalence as a primary disability in Latino communities and its contribution to other disabilities. The lesson will discuss cultural characteristics of the Latino population as well as factors that may stand in the way of effective counseling and/or successful adjustment to a disability. An extensive case study will be used to illustrate issues involved in counseling a Latino client.

Latinos and Substance Abuse

The research base offers some insight into the specific factors to be considered by rehabilitation practitioners serving Latinos with disabilities. **One key factor is substance abuse, which is a primary disorder, a risk factor for other physical and mental disorders, and a barrier for effective vocational rehabilitation. Substance abuse impairs functional adaptability, limiting Latinos' ability to generate improved socioeconomic conditions for themselves.** The correlation between substance abuse and a poor socioeconomic outlook has been reported by McCaughrin and Howard.[7] They found that practitioners serving Latinos work with clients who are significantly poorer, and who are at higher risk of being in the criminal justice system. Substance abuse is a risk factor for HIV/AIDS,[14,15] traumatic brain injury,[16] and for mental disorders.[17] Substance abuse also has been linked to poor rehabilitation outcomes,[18] including high treatment dropout and noncompliance.[19] Latinos who abuse substances also are less likely to perceive a need for services.[20,21] **If rehabilitation practitioners are to improve retention rates and treatment outcomes in the delivery of rehabilitation services, it is necessary to consider cultural factors that may be impeding or facilitating the effectiveness of interventions with Latinos who have a substance abuse history.**

Cultural Considerations

The discussion of cultural factors to be considered by rehabilitation counselors has been divided into two categories: (*a*) the values and beliefs that may affect the adjustment of Latinos with disabilities; and (*b*) mediating factors that affect the expression of the above values by Latinos.

VALUES AND BELIEFS:

Previous investigators[3] have noted that allocentrism, familialism, gender roles, *simpatia* or congeniality, interdependence, *respeto* or deference to authority, a present time orientation, informality, and spirituality are values and beliefs that affect Latinos' adjustment to disability. Allocentrism and familialism refer to the collective supportive environment that Latinos commonly provide for individuals with disabilities. Latinos are relational in orientation, with the needs of the family being more important than the needs of the individual. If someone in the family has a disability, the family simply accepts that this is something with which they will have to live. **Latino families typically adhere to well-defined gender roles for males and females, particularly in families of lower socioeconomic status.** Family members create a climate of support toward people with disabilities, with each member being interdependent with the whole family. Consequently, these values define the family as a primary unit of analysis for treatment planning purposes. Latino families can be supportive of individuals with disabilities because of the centrality of these values. By the same token, these values and beliefs can militate against rehabilitation practitioners and programs insofar as Latinos with disabilities may be hesitant to depend on interventions outside of the family. In addition, it may affect the Latinos' ability to acknowledge their disability if that disability impairs the functioning of the individual within a prescribed role. *Machismo* can contribute to a denial of disability for males; they may perceive the need for a treatment program as a sign of weakness. Women, on the other hand, are supposed to *aguantar*, to tolerate the disability as evidence of strong character. Thus, the mechanism used by many Latinos for coping with a disability is that of denial or passive resignation.[3]

***Simpatia* refers to a preference for presenting an agreeable face to the world, especially in conflictual situations, which could be the case if a Latino family disagrees with a rehabilitation professional about certain aspects of their rehabilitation.** *Simpatia* may play a supportive role, but it also may result in future noncompliance. This value is related to the value of deference to power or authority. Counselors may be perceived as the ones who should make decisions about clients because they are assumed to have the appropriate knowledge. However, this can lead to a sense of disempowerment and lack of participation and initiative in designing one's own goals. **A skillful counselor needs to be able to work with the values of *respeto* and *simpatia* to generate support and participation of Latino clients in developing and implementing a rehabilitation plan. However, they need to be cautious about whether a client has actually internalized the goals, which may influence compliance.[3] Agreement in the office does not necessarily mean agreement in the home.**

A present-time orientation and an emphasis on informal rather than professional relationships may become barriers for establishing and implementing future rehabilitation goals.[3] However, these values can also play a positive role by facilitating the development of a working relationship more readily. Counselors serving Latinos with disabilities could be more effective if they show more role flexibility, within appropriate professional boundaries.[3] Counselors should be aware that dual relationships may be pitfalls fostered by *amiguismo or compadrismo* (socially binding mutual obligations).[22]

Finally, spirituality, or a belief in a higher power, is usually rooted in religion among Latinos. They may believe that a disability is a trial that they must endure as a test of faith. This belief can have a positive impact on the acceptance of a disability.[23] However, when disability is interpreted as a sign of punishment by a higher power, it can lead to shame or hiding the disability; this impedes adjustment.[3] Counselors working with highly spiritual clients can be more effective if they help clients interpret their disability in a way that promotes internal strength and acceptance instead of resignation and passivity. **Moreover, counselors should assess the**

level of hope and trust inherent in the client's religious system and personal beliefs.[24]

MEDIATING FACTORS:

The cultural values described above are not necessarily shared by all individuals of Latino descent. There are several variables that may account for both commonalities and individual differences. Some of these factors are not amenable to change, such as historical (e.g., generational status or nationality) or racial (e.g., black or white Latinos) variables, while other factors can be modified to facilitate adjustment to disability. Among the latter, researchers often mention the variables of acculturation, ethnic identity development, and gender role socialization.[25]

Acculturation

Acculturation is a complex and variably defined construct. **It is a process through which the attitudes, values, beliefs, customs, and behaviors of the minority group change in reference to those of the majority group.**[26] This concept is complex because it is a bidirectional process; persons and environments affect each other, and both are changed by the interaction. To illustrate acculturation, a person who immigrates to a region in the United States where the dominant culture is homogeneous will have a different acculturation experience than a person who immigrates to a region where there is a diverse population. If a person comes to the United States as a political refugee, there may be more resistance to adopting the new culture. A person who immigrates voluntarily to seek a new life may enter into the acculturation process more readily. **With Latinos, acculturation is a common process because, for the most part, they retain significant parts of their culture while adopting some of the characteristics of the U.S. culture.**[27,28] **Those cultural elements most often retained include language and value systems. Acculturation is mediated by both age and generational variables.** The longer Latinos remain in this country, the more likely they are to accept the dominant culture. This is especially true of younger age groups. Katz notes that 62% of Latinos are committed to the family in the immigrant generation, 56% by the first generation, and only 42% by the second generation.[28]

Current literature does not provide much information about the link between acculturation and disability. The link between acculturation and mental health has received more attention. Negative, positive, and curvilinear relationships between acculturation and mental health status have been reported. Highly acculturated people have been found to be less stressed, less likely to abuse substances, and less likely to show psychological symptoms.[27] In other instances, traditionalism or low acculturation has been linked to substance abuse and depression among Mexican-American males but not females. In fact, Mexican-American females show a correlation between acculturation level and substance use. At the extreme ends of the spectrum of acculturation, researchers have found a curvilinear relationship (e.g., too much acculturation or not enough acculturation may interfere with rehabilitation).[26] **Acculturation has been reported to be a critical variable in willingness to seek professional help, treatment drop-out rates, and overall rehabilitation success.**[25,29]

Ethnic Identity Development

A second concept of concern to rehabilitation practitioners is "within-group" identification, or ethnic identity. Ethnic identity refers to how an individual perceives his or her group in relation to a dominant culture. Previous researchers[25,30-32] have described developmental stages which progress from negation of the ethnic identity to integration or internalization of a self-in-relationship. **For example, the model described by Atkinson et al. begins with a conformity stage in which there is a preference for the dominant culture, moves through dissonance and resistance, and emerges to an integrated awareness stage characterized by an inner sense of security and an appreciation of both cultures.**[30] Erikson's model of ego development ranges from a diffuse ego state with little or no exploration of identity to an achieved state characterized by a secure understanding and acceptance of one's own ethnicity.[31]

For the rehabilitation practitioner, the research base provides avenues to explore treatment planning and case management.[33-35] Helms and Carter reported that identity development is associated with client/counselor alliances, self-esteem and stress level.[34] The client's and the counselor's level of ethnic identity development must be

considered in building this relationship. Constantine and Baron coined the term "interactive culture strain" to allude to the stress associated with the development of an ethnic identity.[53] **Risk behaviors such as substance abuse may be linked to particular stages in an individual's ethnic identity development.**[55] High consumption of alcohol or other substances at an early age (e.g., adolescence) may lead to stunted or delayed identity development; this applies to all people.

Gender Role Socialization

Gender role and identity are socially generated processes that can affect bicultural Latinos as much as monocultural Latinos. Social scripting begins at birth and continues through the lifespan.[45] A young Latino immigrating to this country is exposed to different messages about masculinity and femininity, changing the nature of the socialization process. **Thus, gender role socialization is a mediating variable in the cultural adaptation of Latinos. Although cultural variables such as *machismo* and *marianismo* have been linked to potential disruptions in adaptability, these same values and beliefs can be factors that facilitate adjustment to a disability such as substance abuse.** A *macho* male is responsible for using his strength to protect and provide for his family; a female who models herself after Mary, the mother of God for Christians, may provide the sustaining force that holds her family together in the face of a disability. Unfortunately, the negative connotations often supercede the positive if rehabilitation practitioners are not sensitive to the full dimensions of cultural values. A Latino female dealing with an alcohol problem does not have to assume a role of passive resignation; a Latino male dealing with an alcohol problem does not have to deny the disability in the name of *machismo*. Strength and endurance are characteristics that can be integrated into rehabilitation interventions. The rehabilitation practitioner can resort to those values as coping mechanisms to be incorporated into adjustment. They can also use these values to help make the transition to a higher level of functional adaptation. Substance abuse is a substitute for healthy coping; counselors can use cultural values to broaden the range of coping mechanisms.

Assessment of Acculturation and Ethnic Identity

Psychological and behavioral constructs are difficult to measure, and have typically been explored by self-report instruments. There are several assessment tools for acculturation, such as the Measure of Acculturation for Chicanos and Adolescents;[56] the Acculturation Rating Scale for Mexican Americans;[57] the Behavioral Acculturation Scale;[58] and the Bilingualism/Multiculturalism Experience Inventory.[59] **Most of these instruments have been standardized on Mexican Americans and should be used with caution with other Latino groups.** Some of these measures treat the concept as a single continuum (i.e., from unacculturated to acculturated). Others measure acculturation as a multidimensional construct having high and low valences across psychological and behavioral indices. The latter approach results in typologies that are correlated with the levels of adjustment to one's own culture and to the dominant culture.

Birman describes the seven styles of acculturation based on the above dimensions.[60] Table 1 (next page) describes the seven styles in Birman's typology. A blended biculturalism, for example, indicates that a person has a high level of identification and high instrumental competence (behaviors) with both cultures. On the other hand, marginal types show low identity and low instrumental competence with both cultures. **Birman posits that integrated biculturalism, a high identification with one culture but high competence with both, may lead to better adaptation for some individuals.** As with all typologies, one must allow for individual differences in acculturation style that might prove adaptive because of variability in country of origin, political status, and other sociodemographic factors such as the degree of racism in the host culture. Some individuals may resist identifying with a dominant culture if they perceive the culture to be oppressive. In such cases, a blended biculturalism may not be attainable. Practitioners need to build into the assessment process an understanding of how individual differences may affect the level and style of acculturation. **Selection of measurement instruments must depend on the particular needs of the client and the goals of the rehabilitation counseling plan. Rehabilitation counselors should make provisions to collect this type of information at the intake.**

Table 1
ACCULTURATION PATTERNS—AFFILIATION AND INSTRUMENTALITY DIMENSIONS

ACCULTURATION STYLE	PSYCHOLOGICAL IDENTITY	BEHAVIORAL COMPETENCE
Assimilation	High affiliation to host culture	High instrumentality in host culture
Separation	Low affiliation to host culture, high affiliation to own culture	Low instrumentality within host culture, high on own culture
Marginality	Low affiliation to both cultures	Low instrumentality within both cultures
Blended bicultural	High affiliation to both cultures	High instrumentality within both cultures
Instrumental bicultural	Low affiliation to both cultures	High instrumentality within both cultures
Integrated bicultural	Low affiliation to host culture, high affiliation to own culture	High instrumentality within both cultures
Identity exploration	Low affiliation to host culture, high affiliation to own culture[28]	High instrumentality within host culture, and low within own culture[29]

An in-depth initial interview to supplement any paper-and-pencil measure is the recommended means to achieve this goal.

A separate cluster of investigators has focused on the psychological factors that may affect adaptation to another culture. These researchers also use paper-and-pencil instruments to measure the construct called ethnic or racial identity.[31,41,42] Phinney describes three components of ethnic identity, namely, affirmation and belonging, ethnic behaviors or practices, and ethnic identity achievement.[42] The instrument is called the Multigroup Ethnic Identity Measure (MEIM), and has the advantage of allowing across-group comparisons. Rehabilitation practitioners working with diverse ethnic groups might use the MEIM to identify psychological variables, such as self-esteem, that may affect cultural adaptability. This is especially important for practitioners working with clients with substance abuse, as the MEIM correlates well with other measures of self concept. Other instruments have been developed to measure psychological variables related to identity development.[33,43,44]

Case Study

Mr. M is a 35-year-old migrant worker from a rural area of Mexico who has been in this country for eight years and has eight years of formal education. He started drinking alcohol during his early adolescence. Originally he came to the U.S. without his wife and four children, living in a group house made up of migrant working men. During this time his problems with alcohol increased. He sent for his wife and children after he got a stable job doing construction work; they moved to a large metropolitan area. About a year ago, after a weekend of bingeing, he had an accident on the job and sustained a closed head injury. Though he is physically stable now, he has occasional impaired memory and judgement, and poor impulse control. He also complains about physical pain such as headaches, which prevent him from going back to work. He currently is on worker's compensation.

Mr. M spends all of his time at home and his drinking is out of control. He reports that he needs to drink in order to feel better. His wife, a 34-year-old woman in good health, is employed as a maid. She works eight hours a day outside the home, then returns to do everything that is required to maintain the household and the four children. Before the accident, she complained about her husband's drinking but recognized that it is just what men do. She did not worry about it as much because he was working. Now, she tells him that he is worthless. Spanish is the language spoken at home, but both communicate minimally in English outside the home. The four children are fluent in English and often translate for their parents at school or for visits to the doctor. Mr. M has been referred to vocational rehabilitation, but is resistant to counseling because he says he is unable to work. He also fears losing his benefits should his condition improve. Each time he visits the rehabilitation center, he brings his entire family with him. Mr. M must define a vocational goal in collaboration with the rehabilitation

counselor, who is a third generation Latina woman from Puerto Rico. An Individualized Written Rehabilitation Program (IWRP) will be constructed using the following questions:

1. **How are Mr. M's values and beliefs affecting his motivation for using the vocational rehabilitation services?**
2. **What are the mediating factors that need to be taken into consideration?**
3. **How does the counselor adjust her professional role, given the values and beliefs of the client and his family?**
4. **How does the counselor help the client to adjust to personal and environmental changes following a disability?**

INITIAL ASSESSMENT AND PLANNING:

Assessment should start by exploring with the client and his family the beliefs each holds about the disability. Mr. M comes to the meeting with his family; this may be an indication of allocentrism and familialism, meaning that it is the family, not just the individual, that will have to cope with the changed circumstances. The family system becomes the focus of assessment. Mr. M may not perceive the need for any services other than those provided by his wife and children. He may be operating from the assumption that by collecting worker's compensation, he is contributing to the support of his family even though he is not working. **Mrs. M may be caught between two cultures. She may report that everything is fine, and that her husband's disability is something she will have to endure as women traditionally have done in her culture. At the same time, she may realize that she is burning out from taking care of him, the children, and her job outside the home.** Mrs. M leaves the family daily and is performing her job effectively; her acculturation pattern is different from that of her husband. The children are translating for their parents, which reverses the traditional roles between parent and child, with subsequent loss of respect for their father as an authority figure. Their facility in the English language makes their acculturation process vastly different from that of either parent. Mother and children may feel *simpatia* for their father, but their deference to him as an authority figure may be eroding because of his passivity. The entire family may be resisting any form of rehabilitation planning that would require focusing on the future; Mr. M is not willing to look beyond the present, a time orientation that is consistent with his culture. When asked about the future, he replies that God will provide. **In-depth intake interviews, self-report measures of acculturation, and counselor observation of family interactional patterns are the major activities in the initial phase of planning for service delivery.**

DEVELOPING THE IWRP:

Having assessed the values and beliefs of the family of Mr. M, the counselor now must take these values into consideration when developing the IWRP. **To get the client involved in his own rehabilitation plan, appeals can be made to the positive values inherent in the traditional system described above.** The *macho* value requires that Mr. M preserve his dignity, respect others, and care for his family. **The counselor must stress how his involvement and participation in his own rehabilitation plan may fulfill the positive values of *machismo*.** In order to do this effectively, the counselor must be aware of his or her own understanding of *machismo*, and of how his or her own cultural group views its positive and negative dimensions. Some of the negative attributes of *machismo* include high rates of violence, the domination of women, and the excessive use of alcohol.

As the counselor meets with the family member, he or she takes into consideration the degree of identification that each family member has toward Latino culture and toward the host culture. He or she also does a self-assessment of values and beliefs about her own cultural identification, determining the potential intersections and differences. The next step is to use this information to help the family build a relationship with Mr. M as a person with a disability; this relationship may require personal adjustments and will involve all of the members of the family. For example, the wife and children can be helped to understand that Mr. M is resisting his rehabilitation plan due to a lack of trust in the host culture and his perceived lack of behavioral competence to learn a new job (a separation acculturа-

tion pattern). This understanding can help them cope with their negative feelings toward Mr. M while developing a more constructive attitude. At the same time, he can begin to understand that his traditional values and his strong identification with his culture of origin is compatible with learning new behaviors that would make him instrumentally competent within the host culture (integrated biculturalism). **The likely end product would be that the whole family may adjust to the disability in a manner that preserves the cultural values and beliefs of both cultures.** Using a psychoeducational intervention about acculturation differences, Mrs. M could be encouraged to learn that her acculturation pattern is one of identity exploration whereby her need to hold the family together compels her to function effectively in the majority culture but precludes her full participation in the culture with which she most identifies. This type of intervention normalizes her experience and has the effect of reducing her stress level. Identity exploration and integrative biculturalism can be mutually supportive in the sense that she could be a model of resourceful competence and Mr. M could validate her desire to belong to the culture of origin. Mutual support derived from their understanding of each other's acculturation pattern is compatible with the values of familism, allocentrism, *simpatia*, and *respeto*.

Client/Counselor Working Relationship

Perhaps the biggest challenge to the rehabilitation counselor is the establishment of an effective client/counselor relationship. As discussed earlier in the case of Mr. M, the values of informality and present-time orientation held by clients could pose a barrier to counselors who are unaware of them or are unable to adapt their professional role to make it compatible with these values. **Again, key mediating factors to consider would be acculturation pattern, ethnic identity, and gender role socialization of both client and counselor. It is not a matter of matching a Latino client with a Latino counselor; rather, it is a matter of establishing the degree of role flexibility based on how client's and counselor's acculturation patterns, cultural identity, and gender role socialization match.** Role flexibility refers to the counselor's openness to adapting to differences in time orientation, to extensions of the traditional time allotted for rehabilitation counseling, to language formality or informality (*tu* vs. *usted*), and to the amount of self-disclosure necessary for building an effective relationship. For example, **if a counselor has a blended bicultural pattern, and her primary client is monocultural in both dimensions, that counselor would have to exhibit the greatest role flexibility. On the other hand, if a counselor and client are bicultural on both dimensions, little role change is required for the working alliance to be established.**

There are variations in the need for role flexibility across the different combinations of acculturation patterns described above. For example, consider a case where a counselor has an acculturation pattern of blended biculturalism on both dimensions, and who has a client whose acculturation pattern is one of integrated biculturalism (i.e., the client is psychologically affiliated with his or her own culture but involved behaviorally in both cultures). In this case, some flexibility by the counselor would be required to facilitate exploration of the cultural dimensions of the presenting problem without inhibiting client expressiveness or demeaning the client's affiliation.

Person/Environment Focus

Traditionally, when planning and delivering rehabilitation services, the major focus has been on helping the client to adjust as an individual.[46] The underlying assumption here is that the family and social environment are passive participants, or conversely, that they exert negative pressure on an individual with a disability.[47]

Rehabilitation counselors who are aware of other cultures must attend to the environment as a focus for intervention.[48] Rehabilitation counselors should assess both persons and their environments, as well as mediating factors between the two (e.g., acculturation) in constructing a rehabilitation plan. Hurst and McKinley provide a model for considering points of intervention focused around persons, environments, or potential mismatch.[49] When assessing the problems following Mr. M's disability, there might be a person/environment mismatch, a lack of information in the environment, a con-

flict within the environment, or an environmental deficit, in addition to personal deficits arising from the disability. In the case of Mr. M, the previous work site may no longer be compatible with his vocational goals or the environmental press of his employer (person/enviromnent mismatch). Mr. M.'s workplace might be difficult to enter and adjust to, perhaps being physically inaccessible, monolingual, and/or monocultural (i.e., a lack of information in the environment). It is also possible that the work environment has made no provisions for accommodating the needs of the person with a disability (i.e., an environmental deficit). Table 2 shows the different interventions associated with these four person/enviromnent categories, adapting Hurst and McKinley's framework for culture and disability factors.

Table 2
SAMPLE INTERVENTIONS BY PERSON AND ENVIROMNENT CATEGORIES

Category	Sample Intervention
Person/enviromnent mismatch	Assess client vocational goals, level of acculturation, and find the best fit for these in a new work setting.
Lack of information about the environment	Analysis of the workplace, to include role of acculturation and language in performance of job.
Environmental conflict	Examine workplace policies, to assure there are no conflicting messages regarding culture and disability.
Environmental deficit	Assessing need for and implementation of job accommodations that reflect culture and disability.

Pitfalls to Becoming a Culturally Competent Counselor

The intervention model that we have presented in this article is an attempt to move the rehabilitation counselor beyond traditional multicultural counseling strategies. There are three pitfalls that must be considered by the culturally sensitive counselor: (1) **stereotyping;** (2) **a focus on deficits within the person; and** (3) **matching client and counselor based solely on race or ethnicity.**

There are three assumptions underlying our conceptualization. We have avoided the pitfall of stereotyping that is inherent in multicultural counseling by urging that counselors incorporate mediating factors such as acculturation patterns, cultural identity development, and gender role socialization. It is our position that the process of stereotyping is a necessary first step in the process of generating culturally sensitive hypotheses about client needs. Values such as informality or *machismo* are only stereotypical if the counselor assumes that all clients from a given cultural group ascribe to these values equally. Rehabilitation counselors must consider person/enviromnent interactions in addition to the standard focus on deficits within the person.

One must consider the many factors on which the client/counselor relationship may be built, beyond a match between race and/or ethnicity. The skilled rehabilitation counselor is one who considers culturally sensitive counseling a dynamic process of analysis and role implementation that encourages as much flexibility in the counselor as it does in the client. Persons with disabilities, their counselors, and the environments in which they both work will benefit from this inclusive approach.

Summary

Latinos are a rapidly growing ethnic group in the United States. Mexican-Americans will be the largest ethnic group at the turn of the century. Latinos are less educated, have lower incomes, lower employment rates, and less insurance coverage than non-Latino whites. The number of Latinos with disabilities is projected to grow faster than that of any other group. Many rehabilitation counselors will be working with a largely Latino clientele if the above projections prove valid. For rehabilitation counselors to be culturally competent in working with Latinos with disabilities, they will need to assess the

relevant values and beliefs of the culture, as well as mediating factors such as acculturation patterns, cultural identity development, and gender role socialization. Rehabilitation interventions should consider person/environment interactions as well as defecits within the client. Rehabilitation counselors should incorporate a self-assessment of their own cultural filters in building the working alliance with Latinos with disabilities, with special attention to defining the way that counselor-held stereotypes might potentially influence the counseling process. Finally, an inclusive approach to assessment and treatment planning will facilitate the adjustment of Latino clients in rehabilitation counseling.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

1. **The disability rate of Latinos is:**

   A. Similar to the total U.S. population except for higher rates of cancer and diabetes mellitus.

   B. Similar to the total U.S. population except for lower rates of AIDS, cancer, and diabetes.

   C. Much higher than the general U.S. population in all categories.

   D. Much lower than the general U.S. population in all categories.

2. **According to the authors, the Latino value which refers to a preference for presenting an agreeable face to the world, especially in conflictual situations, is:**

   A. Respeto

   B. Aguantar

   C. Simpatia

   D. Marianismo

3. **According to the model described by Atkinson et al., the developmental stages often followed in ethnic identity:**

   A. Begin with dissonance and resistance, followed by conformity to and preference for the dominant culture, and ending with an integrated awareness characterized by an appreciation of both cultures.

   B. Begin with conformity to and preference for the dominant culture, followed by dissonance and resistance, and ending with an integrated awareness and an appreciation of both cultures.

   C. Are curvilinear, beginning and ending with conformity to and preference for the dominant culture.

   D. Are curvilinear, beginning and ending with an inner sense of security and an acceptance of one's own ethnicity.

4. **Using Latino cultural values in the rehabilitation of Latino clients with substance abuse:**

   A. Is counterproductive because the use of these values will hinder or delay the client's acculturation to the dominant culture.

   B. Is not possible because the rehabilitation counselor cannot understand the full dimension of these values and implement them meaningfully.

   C. Should be the basis for all work done with all Latino clients regardless of age or generation.

   D. Can help demonstrate to the client that the counselor does not hold negative, stereotyped views of the Latino culture.

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Directions in Rehabilitation Counseling
Volume 9 Lesson 2

Addressing Sexuality Issues in Clients With Physical Disabilities

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Introduction

Medical interest in sexuality and sex therapy is rooted in the pioneering work of Masters and Johnson, originally published in the 1960s.[1] Their work in human sexual response marked a new era in which sexuality became a legitimate area of clinical work and scientific investigation. Clinical observations from their laboratory were widely reported in the media of that era and ultimately served as an important component of the sexual revolution of the 1960s. In addition, the treatment techniques developed by Masters and Johnson served as a foundation for clinical sex therapy and have been extensively utilized in the treatment of male and female sexual dysfunctions.

For people with disabilities, the acceptance of sexuality as a justifiable and sanctioned area of rehabilitation has been much more controversial and progress has been limited.[2] **Historically, people with disabilities received little information on sexuality and were often regarded as nonsexual and incapable of an intimate relationship. This misperception has not only persisted in the general population but has been prevalent in the rehabilitation community as well.** Despite the similarities in sexual functioning for people with and without disabilities, the tendency has been to emphasize the differences between the two groups and to view people with disabilities as sexually impaired.[3] Obviously, this tendency goes much deeper than issues of sexuality and is a reflection of society's general discomfort with people who have disabilities. In reality, the sexual rights and responsibilities of people with disabilities are identical to those of nondisabled people. Everyone, regardless of disability, has the right to sexual expression and the right to develop to the fullest potential in all aspects of life. **This lesson will familiarize the rehabilitation counselor with the issues concerning sexuality in clients with disabilities and will improve the effectiveness and sensitivity with which these issues are dealt.**

Background

Historically, addressing sexual issues during the rehabilitation process dates back only to the 1970s when Theodore and Sandra Cole developed the "Sexual Attitude Reassessment" program (SAR) to train rehabilitation professionals.[4] These early workshops quickly gained in popularity throughout the rehabilitation community and for many years were offered at major medical facilities in the United States and Canada. These programs focused on communication and the clarification of values. Their purpose was to increase the practitioner's level of comfort with and awareness of sexual issues among people with disabilities. The SAR programs were very successful but tended not to provide the counseling skills necessary to assist individuals in their sexual adjustments after disability.

To some extent during the 1970s, the idea of sexual education for people with disabilities was academic. People in the field of rehabilitation had begun to recognize the need for sexuality services, but there was little agreement as to how and when these services should be provided. There was also little agreement as to who should provide sexual education. Patients were often discharged from rehabilitation with no information because various members of the rehabilitation team assumed that practitioners of other disciplines had addressed sexual concerns.[5]

The lack of coordination of sexuality services and the failure to address these concerns during acute rehabilitation perpetuated the erroneous notion that information on sexuality was of little importance to people with disabilities. Ultimately, people with disabilities began to demand further information regarding their sexual functioning and their capacity to have children. Medical and rehabilitation professionals were forced to respond to the needs of their clients.

First, to clarify the issues discussed in this lesson, it is important to define sexuality. **Sexuality is the integration of physical, emotional, intellectual, and social aspects of an individual's personality. It is an expression of the total personality evident in everything done by a person.[6] Interactions with others, personal hygiene, speech, dress, and expressions of affection are all an important part of sexuality. Given this broad definition, sexuality may be regarded as an avenue toward intimacy and may be directly or indirectly affected by the presence of a disability.** Disabilities such as blindness, burns, or cancer, for example, may not directly impair genital functioning but can affect communication, body image, and self-esteem. Ultimately, disruptions in these areas may compound physical and psychological well being and result in various secondary conditions requiring medical treatment.[7]

Developmental Issues Of Sexuality

The theory of developmental tasks was originally discussed by the psychologist Erik Erikson.[8] These developmental stages represent the critical periods of development from birth to death. As individuals move through life, they encounter a number of tasks set by their cultural milieu and by biologic imperatives. These developmental tasks are particularly critical because they must be mastered if children are to develop more mature social and interpersonal skills. **When disability occurs, not only are the current developmental tasks threatened, but the person, at least temporarily, regresses to an earlier stage of development. This has broad implications for an individual's psychological and sexual adjustment. Because the person's sense of masculinity or femininity is an integral part of these developmental milestones, disability can create confusion and conflict in both gender identity and gender role—identity and role being different aspects of the same process.** For people with disabilities, confusion about both gender identity and role can make the adjustment process more difficult, especially without adequate role models and sources of emotional support.

Gender identity is the inner experience of one's self as male or female; gender role is the outward expression of that identity.[9] Without resolution of these conflicts, more complex tasks, such as the formation of relationships and the achievement of a positive self-esteem, may never occur. **Thus, for a person with a disability, a healthy sexual adjustment and the ability to achieve intimacy depends on the successful resolution of developmental tasks at the time of injury or onset of illness.**

Congenital disabilities often prevent a child from gaining essential information about the body. Overprotection by parents, discouragement of sexual exploration, and a lack of adequate socialization often add confusion to male and female roles. Confusion regarding sexuality lends itself to later feelings of inferiority and difficulty relating to members of the opposite sex. Children with a disability are often isolated from peers and may regard themselves as "not equal" to their playmates.[10] These deficits in the early sexual education of a child can easily become more difficult to manage later in life.

During puberty and adolescence, the achievement of sexual identity and acceptance in peer group relationships are the goals to accomplish. As the adolescent grows and enters young adulthood, one of the primary tasks is the development of intimacy and the concurrent strivings toward independence. Traumatic injury at this time threatens these important peer relationships and fosters dependency on the family unit. Adolescents with a disability often feel unattractive and ashamed of their bodies. Subsequently, they feel unwanted by the opposite sex and incapable of establishing a meaningful relationship. **Without a sense of sexual identity, older adolescents may even lack the ability to make vocational and educational decisions or to assume responsibility for their own behavior.** Thus, future emotional growth is threatened.[11]

The developmental process can be further complicated for young people with gay and lesbian orientations. More than simply a matter of having a same sex partner, gay and lesbian identity often is similar in scope to ethnic or racial identity, involving identification with the values of a subculture.[12] The process of forming a gay or lesbian identity evolves in stages from confusion and conflict to acceptance. **For the person with a disability, the presence of homosexual issues can further complicate an already difficult sexual adjustment.**

Aging is another often overlooked developmental stage.[13,14] Although the reality is that older adults can continue to be sexually active throughout their life spans, internalized negative attitudes can inhibit sexual expression in later years. The stigma against aging is even greater in the disabled community than in the culture at large and is experienced with fear at earlier ages than for individuals without disability.

Psychological Considerations

Adjustment to a physical disability or illness is a gradual process. **The individual must mourn losses and develop coping strategies that will validate the meaningfulness of post-injury life.** Successful adjustment depends on the recognition that choice is still available and is influenced by many factors such as type of illness or injury, age at onset, physical health, and quality of social supports.

Successful sexual adjustment requires the same gradual and sometimes painful emotional process. Losses need to be grieved so that the remaining strengths can be developed and nurtured. However, because of different personality styles, not everyone completes this difficult adjustment. Some individuals, for example, may have experienced profound periods of grief and trauma earlier in life due to emotional, physical, or sexual abuse.[15] Perhaps there were few emotional supports during childhood and the grieving may have extended for prolonged periods of time. The resolution of pre-disability psychological issues may be necessary for the individual to master the demands and responsibilities of living with a disability.

After a traumatic disability, individuals frequently go through a period of reduced sexual drive or performance. Others go through a period of sexual acting out, presumably to validate their survival and sexual identity. However, substantial numbers of people fail to resume an active sex life after injury due to misinformation, problems of adjustment, or shame regarding body image and functioning.[6] **Those that do assume an active sex life after injury are often advised by rehabilitation staff members to keep separate the roles of sexual partner and care provider.[16,17] Having one's sexual partner provide intimate medical care can be destructive to the relationship.** Mixing these roles often places one member in a needy, helpless position while the other member is perceived as powerful and giving. A lack of equality upsets the balance of power in a love relationship, tending to dilute feelings of intimacy and become the source of feelings of resentment and anger.

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For a person with a disability to achieve a satisfying sexual adjustment, it is necessary to value the new level of sexual ability instead of trying to regain pre-injury sexual abilities. These adjustments often come slowly, after a period of intense grieving and sadness. Many individuals find that emotional relationships and physical intimacy do not occur for many months following discharge from the rehabilitation center. Even then, the process can be slow and painful. Sexual experimentation may or may not be a part of this adjustment process, depending on the individual's ability to take risk and tolerate feelings of vulnerability.

Clients with disabilities who achieve success in their sexual functioning often do so because of increased communication and a willingness to experiment with developing romance and intimacy as well as technique. They are secure enough to realize that not every experiment will work and they value nongenital erogenous zones. They are typically more comfortable with their own bodies and continue to feel a sense of self-worth and self-respect.[1] As a result, partners also feel validated and perceive the sexual relationship to be warm and caring and a mutually enjoyable experience.

The importance of communication cannot be overstated. **The development of skills in communication about sexual topics and methods of pleasure is the single most critical aspect of successful sexual adjustment.** Specific and immediate communication between partners can relieve intense feelings of anxiety, fears of rejection, and concerns about physical safety. For this reason, psychological counseling and education about sexuality while in rehabilitation must emphasize these areas and provide individuals with the opportunity to develop and strengthen these skills.

Although psychological considerations need to be addressed in all discussions regarding sexuality, physical functioning is equally important. Often in rehabilitation, it can be extremely supportive and helpful to clients if a sensitive discussion regarding physical capabilities is provided as soon as the individual is ready. Providing accurate information can be an important means of reducing stress and gaining control over anxiety. Usually, a client will indicate his or her readiness by asking questions regarding attractiveness, dating, relationships, and intimacy. **Even if the individual does not raise these concerns during hospitalization, it is usually appropriate for staff members to offer information if the client seems interested and curious.** Such topics as libido, erections, orgasms, lubrication, fertility, mobility, sensation, and bladder functioning are all relevant to the sexual functioning of people with disabilities.[18,19]

Sexual Desire

Inhibited sexual desire, now known as hypoactive sexual desire disorder, is characterized by persistently low or absent sexual fantasies and desire for sexual activity, not due to a substance abuse or primary psychiatric disorder. The sudden onset of disability or the more chronic issues of malaise, pain, fatigue, or stress can contribute to decreased libido.[20] Low desire after a traumatic disability is, for the most part, of limited duration. **As adjustment proceeds, sexual desire often returns slowly and steadily. The level of depression after disability may in fact be the single greatest factor in determining the level of desire for sexual activities.** If depression is more severe, or if there are substantial relationship issues that were present before or emerged after the disability, the return of sexual desire may be more protracted and may require counseling or medications for it to resolve. Depressions associated with disability are complex medical problems that require an in-depth evaluation and treatment plan. Often a psychiatric or psychological consultation may be warranted. In other instances, the precipitating factors responsible for the loss of sexual desire may be less apparent. Additional effort will be required to unravel the chain of events responsible for diminishing the libido. Changes in sexual desire may also be somewhat variable over time, depending on the emotional well-being of the person with the disability and his or her partner.

In addition to traumatic disability, many chronic illnesses can result in inhibited sexual desire, either temporarily or permanently.[21,22] Neuroendocrine disorders, cancer, heart disease, renal failure, liver disease, chronic lung disease, drug or alcohol addiction, and multiple sclerosis are among the conditions which can have a physical effect on sexual desire.

Male Sexual Functioning

The capacity to achieve erections is often altered in men who sustain damage to the central nervous system (e.g., spinal cord injury and stroke, as well as progressive disabilities such as multiple sclerosis and diabetes). **Men with congenital disabilities such as cerebral palsy and muscular dystrophy typically retain the ability to achieve erections but more often report difficulties in mobility, positioning, and communication. If erections are altered, such as with spinal cord injury, the man may still be capable of reflexogenic erections.** Although these erections may not be suitable for penetration, they can usually be achieved and sustained by ongoing manual stimulation of the genital area. Some authors have suggested that techniques such as positioning the flaccid penis in the vagina can be mutually satisfying to the couple. Other health professionals have emphasized the importance of medical interventions to improve erection quality.[16,23,24]

Sensory disturbances are also a prominent symptom in many of the disabilities that affect central nervous system functioning. Many individuals report a complete loss of sensation below the level of injury or lesion. Other men may experience some sensation in the genital area, although these areas may not be as sensitive as prior to the onset of disability. For example, the client (man or woman) may be able to differentiate hard touch but unable to experience soft touch or stroking. Areas of intact sensation, usually above the level of injury, are often considered hypersensitive and can be another source of erotic pleasure. In other cases, these areas may be sensitive or painful when touched. Intensely erotic areas that are often used in sexual activity may be at the nipple line or in the vicinity of the ears, scalp, and neck. Because of the wide variations among different individuals, it is important to encourage clients and their partners to experiment with sexual functioning in order to gain a better understanding of their own unique situations.

In recent years, procedures such as penile injections, implants, vacuum constrictive devices (that fit over the penis) **as well as various surgical procedures have gained increased popularity for men with neurogenic erectile difficulties. Despite problems associated with these various devices, such as scarring, infection, or mechanical failure, clients satisfaction has generally been positive.**[25] Dissatisfaction has usually been caused by decreased penis size, firmness of the erection, temperature of the penis, or difficulty in manipulating the device. Other couples have reported a loss of spontaneity with love making and a feeling that use of a mechanical device seems unnatural and a deterrent to their sexual expression.

There is much attention paid to the injection of various drugs into the penis, but oral medications to improve erections are clearly the cutting edge in erection research. There will be a tremendous market for such oral medications once FDA approvals have been obtained. Currently, medications that have great potential, such as Viagra, are being tested for men with erection problems. Other centers are doing clinical testing on various hormone therapies to improve male sexual functioning. The results of these studies seem very promising and breakthroughs are happening on a regular basis.

The ability to diagnose and treat infertility in men is another area that continues to improve. For men with disabilities of the central nervous system, fertility rates have generally ranged anywhere from one to ten percent.[26] Reports of pregnancies were typically undocumented and anecdotal. Problems were either due to difficulties of sperm retrieval or poor sperm quality. Newer methods of retrieving sperm through electroejaculation and vibratory stimulation demonstrate positive results.[27] In some cases, surgical sperm aspiration coupled with in vitro fertilization are offering new hope for couples wishing to have children. Also, techniques to reduce testicular temperatures are having positive results on spermatogenesis and sperm production. Of the advanced procedures, intracytoplasmic sperm injection (ICSI) has offered hope to many couples when poor sperm quality has been an issue.[28] With ICSI, sperm is collected from the man through an assisted ejaculatory procedure, if necessary. A single sperm is then injected directly into the egg, which has been retrieved through a surgical procedure. Once the egg has been fertilized, it is then placed back in the uterus. Because of the effectiveness of the ICSI procedure, a growing number of reproductive clinics are adopting the procedure and using it for men with disabilities who have poor sperm motility and quantity.

As a result of these new procedures, the feasibility of parenthood for people with disabilities has greatly improved. Ten years ago, men were often told that fatherhood was not possible after a disability and were discouraged in their hopes of having a child. Currently, if the man with a disability produces sperm, there is the potential for fatherhood. Rehabilitation professionals who provide education to their patients need to realize that these new procedures are available and that parenthood is possible.

Female Sexual Functioning

The literature on sexuality for women with disabilities has historically lagged behind the research being conducted for men with disabilities. Some authors have suggested that age old myths regarding female sexuality, cultural stereotypes, and the low incidence of traumatic disability of women are to blame.[29] **This situation is changing as women's sexuality and wellness have become an increasing priority for funding sources.** These sources include the National Institute on Disability and Rehabilitation Research and the National Institute for Health. Despite the growing attention, there are still many unanswered questions that have far reaching implications for the woman with a disability.

For the most part, changes in the female genital tract are most common after neurologic trauma or disease. These changes may affect vaginal lubrication, labial swelling, clitoral swelling and regression, and the perception of orgasm. Most of the reports on female sexual changes following disability tend to be anecdotal with little scientific basis. Since many of the findings tend to be self-reports, some researchers have suggested that the existing data is insufficient to obtain quantifiable data on sexual arousal.

One of the few scientific studies that examined sexual relationships following spinal cord injury was conducted by Sipski and Alexander.[30] They questioned 25 female spinal cord injured patients about sexual activities and frequency of sex pre- and post-spinal cord injury. Forty percent of their subjects resumed sexual activities within 6 months of injury and an additional 24% resumed sexual activity within two years of injury. Frequency of activity was documented to decrease after the onset of disability. Whereas 64% of women had engaged in sexual activity at least weekly pre-injury, only 48% were sexually active at least weekly post-injury. The number of sexual partners was also evaluated and no significant difference was noted pre-injury vs. post-injury for the group as a whole or based on neurologic injury. Finally, whereas sexual intercourse was the woman's favorite sexual activity pre-injury, kissing, hugging, and touching were preferred post-injury.

Many aspects of a woman's sexuality may be altered after a traumatic injury, including libido or desire, arousal, response, and specific sexual behaviors. Complications encountered by women with traumatic disabilities include: management of autonomic hyperreflexia (drastic changes in blood pressure), management of bowel and bladder continence, and management of spasticity. For women with multiple sclerosis and spinal injury, lubrication may become reflexogenic, facilitating penetration of the vagina. **Changes in desire and arousal may result from the impact of changes in her physical status and her perception of herself, from role changes that may occur as a result of injury, or from the anger and depression that often accompany the onset of a disability.**[32]

Current research on female sexuality is exploring issues related to vaginal contractions; intensifying perception of orgasm; and stimulating vasodilatation of the pelvic region. All require further investigation, but the research indicates a renewed interest in the field and a commitment to understanding female sexuality and disability. Most importantly, newer research provides a renewed sense of hope for women with disabilities, offering important applications for clinical practice.[32]

Of special note in the current women's research is data regarding orgasms in women with spinal cord injury. **Sipski and Alexander[33,34] have demonstrated that a large percentage of women with spinal cord injury achieved orgasm regardless of pattern or degree of neurological injury.** Furthermore, they have ascertained that no consistent characteristics have been identified that would allow the prediction of which women with spinal cord injury would be able to achieve orgasm. **This data seems to indicate that sexual education for women regarding their sexuality plays an important role in their overall sexual adjustment and is a determining**

factor in their general sexual satisfaction. These studies have had vast implications on previous assumptions regarding women with disabilities and have sparked renewed interest in the physiological sexual responses in women following the onset of disability.

The issue of birth control is somewhat problematic for women with disabilities. Zasler[35] suggests that in the age of AIDS, the choice is no longer so controversial; unless the relationship is monogamous and long standing, the safest method is a thick latex condom with a spermicidal foam or jelly containing nonoxynol-9. The combination of a diaphragm and foam also reduces the risk of pregnancy, but not STDs. However, the limited dexterity of many women with disabilities makes it difficult to insert and remove. Reduced sensation also prevents detection of an incorrectly placed diaphragm, which might cause irritation and subsequent bladder infection. The partner or personal care attendant in these cases might assist in placing the device.[36]

Birth control pills are known to increase the risk of blood clots, signified by leg pain in the general population. Women with mobility impairments are already at higher risk for developing blood clots because of reduced circulation in the lower extremities and may not be able to sense the warning pain. For this reason, some health experts consider them contraindicated. However, no empirical studies have been conducted to document the increased risk.[36] Those people who do recommend the pill for women with reduced mobility argue that the new low dose pill actually minimizes the risk. **If birth control pills are being considered, it is important to know that blood clots are more common in the first six months following traumatic injury. Therefore, they should not be prescribed before that time has elapsed. Follow-up examinations should occur twice per year.**[37]

Issues regarding menstruation and reproduction are also important to communicate to women post-injury. For most women with traumatic disabilities, menstruation returns after a period of approximately six months following injury. Therefore, birth control must be addressed at this time should the woman become sexually active and not desire to have children. Typically, fertility issues do not change post-injury. A woman with a spinal cord injury, for example, is able to conceive a child and carry it through a normal pregnancy and delivery. Delivery is usually done by cesarean section and close medical supervision is important to monitor sudden shifts in blood pressure caused by a condition known as autonomic dysreflexia.

To improve the sexual satisfaction of women with disabilities, new treatments must be developed and documented. New data on reproduction and wellness must be communicated to women who have disabilities. These may include medical treatments such as the use of biofeedback and vibratory stimulation or psychological approaches such as patient education or new forms of sexual counseling.[34] Only then will women begin to have the information that they deserve regarding their bodily processes and their sexuality.

Staff Training and Program Development

Education in sexuality is a critical feature of any training for rehabilitation professionals. **Sexuality education should also be considered essential for any comprehensive rehabilitation program. This should include workshops aimed at values clarification as well as those that provide specific information on disability and sexuality.** In addition to the training curriculum, administrative support of the sexuality program must be evident to staff members, patients, and their families. This administrative approval establishes a positive therapeutic environment with openness, empowerment, and caring as the foundations of the rehabilitation process.

Although not all staff members need to be sex counselors, all should feel comfortable with the topic of sexuality and communicate a sense of openness about it. This necessitates an awareness of one's own values and reactions to sexuality-related issues. Anxiety, shame, or discomfort about sexuality are common.[37] Putting this anxiety aside and becoming aware of one's personal reactions to sexual issues is a long process that requires sensitization, education, and practice. Often a first step in reducing this tension is acknowledging one's feelings to another person. A peer support group or discussion with a colleague can be especially helpful in overcoming personal barriers about sexuality.

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In addition to processing personal feelings about sexuality, specific information on sexuality and disability must also be taught to staff members. Without up-to-date information, staff members will only add confusion to an already difficult topic. Even worse, the patient and his or her partner could be given incorrect information that would have a negative effect on their relationship and their overall adjustment. An ongoing lecture series is often helpful in this regard. Typical issues addressed in such a program include sexual anatomy and physiology, effects of medications, physical functioning, treatment options, counseling techniques, professional roles, and gay and lesbian issues.

The development of a sexuality committee within a facility is often the method of choice in addressing ongoing sexual issues and problems.[37] Ideally, a member of the administration should serve on the committee. This validates the committee's function and provides a sense of security, safety, and recognition to its members. The development of institutional guidelines and procedures is usually the first task of the committee and often its most important function. It is essential that the committee establish guidelines on some of the most sensitive interactions that occur in the day to day functioning of the institution. **Issues to be addressed typically include whether to establish a privacy room; masturbation; partner sexual activity; dissemination of birth control information and supplies; prevention of sexual assault; prevention of sexually transmitted diseases;[38] and policies concerning the relationships between clients and staff members.**

In-service education programs often will raise concerns about staff-client interactions. This is usually the primary area of staff anxiety and sensitive discussion is most often welcomed and appreciated. In addition, an overview of behavior modification techniques can be helpful. This should be geared especially around sexual issues and should be combined with theoretical discussions of reinforcement schedules and behavioral contingencies. Finally, the importance of limit-setting and professional boundaries should be discussed and emphasized.

Summary

For people with disabilities, there are multiple restrictions on the expression of sexuality. These stem from cultural biases, social ignorance, and unfounded fears regarding the person with a disability. For homosexual men and women, these fears and biases are significantly intensified and there is a serious lack of information and resources available in the area of sexual health. The responsibility of medical professionals is to achieve a balance between protecting the rights and privacy of hospitalized patients and providing a safe and enriching environment. As staff members are retaught to refrain from imposing restrictive values and excessive control on clients, a therapeutic environment that fosters self-esteem and sexual growth will unfold in the rehabilitation setting.

In the last decade, we have witnessed tremendous progress in the areas of sexuality and disability. However, there is much left to be done so that all men and women are included in this revolution. What once began as a passing fad outside of mainstream rehabilitation has now become an accepted standard of practice for the rehabilitation team. Education about sexuality and disability is a critical component of the rehabilitation process.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

5. **Which one of the following statements is correct?**

   A. The level of depression after disability has minimal impact on a person's sexual activities.

   B. After a truamatic disability, some individuals go through a period of reduced sexual drive and/or sexual acting out.

   C. Having one's sexual partner provide intimate medical care is encouraged to foster a closer relationship.

   D. Persons with a disability should strive to regain pre-injury abilities rather than settle for new sexual abilities.

6. **As children, individuals with congenital disabilities often were:**

   A. Over-protected by their parents.

   B. Discouraged from sexual exploration.

   C. Not given adequate socialization opportunities.

   D. All of the above.

7. **Which one of the following statements is false?**

   A. Men with congenital disabilities such as cerebral palsy and muscular dystrophy typically lose the ability to achieve erections.

   B. Sensory disturbances are prominent symptoms in many disabilities affecting the central nervous system.

   C. The capacity to achieve erections may be altered in men who sustain damage to the central nervous system.

   D. If erections are altered, a man may still be capable of relfexogenic erections.

8. **Which one of the following questions is *false* concerning female sexual functioning?**

   A. Use of birth control pills are known to decrease the risk of blood clots in women with mobility impairments.

   B. Changes in the female genital tract are most common after neurologic trauma or disease.

   C. Birth control pills should be prescribed after the first six months following traumatic injury.

   D. All of the above.

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Directions in Rehabilitation Counseling

Volume 9 Lesson 3

Counseling Women During Menopause: An Integrative Approach

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Introduction

Menopause is one of the most compelling topics of the late 1990s. Its rise to prominence is attributable to several converging factors: the sheer number of women now moving into mid-life; new research that links menopause with debilitating diseases; controversy surrounding appropriate treatments; and American culture's fear of aging. During this normative mid-life transition time, women experience significant changes in biological, psychological, and social functioning. These changes, for which individual responses are highly variable, are not well understood.[1,2]

Whereas the majority of women report minimal disruption to life due to menopausal changes,[3,4] 10%–30% of women experience moderate to severe physical and/or psychological.[5,6] With the predicted number of menopausal and postmenopausal women reaching 50 million by the year 2010,[7] a percentage as small as 10% represents a subset of five million women who may experience seriously disruptive symptomatology.

The dominant paradigm for menopause is biomedical, a model that emphasizes aging, deterioration, and disease. Although this model contributes a valuable component to the complex picture of menopause, it basically ignores all other influencing factors.[8] The combination of conflicting results of medical research,[9–11] the stigma attached to menopause,[8,12] and the dearth of information on psychosocial issues related to this period of life contribute to confusion, anxiety, and psychological distress for women in mid-life.[12]

Rehabilitation counseling, with its holistic and integrative approaches to life planning, is well suited for assisting women as they move through this transition time into the next trimester of life. In this lesson, information is provided to enhance the knowledge of rehabilitation counselors about the complex dynamics of menopause. In addition, suggestions for helping menopausal women are discussed.

Definitions

Menopause has been defined as both a single biological event and a process that includes multiple stages, involving up to 15 years of a woman's life.[6,13] Inclusion criteria for the different stages (premenopause, menopause, perimenopause, and postmenopause) can vary according to health care providers and researchers, causing confusion and misunderstandings.

TERMS:

Menopause

Some of the confusion surrounding menopause involves the lack of one specific definition.[13] The literature tends to define menopause based upon one of many different models, and may therefore use age, menstrual cycle patterns, presence of symptoms, or hormone levels as the defining criteria.[14] **Strictly speaking, menopause is an event which denotes the last menses or menstrual period in a woman's life.**[15] This event may be the result of medical interventions such as hysterectomy, chemotherapy, and radiation, or natural, biologically timed processes.[16] Determining the last natural menses is difficult because the years prior to menopause are characterized by irregular cycles. **The most commonly accepted definition of menopause states that menses must have ceased for at least one year.**[17] **This definition proves to be of little benefit to women, because one can only determine the menopausal state retrospectively.**

Menopause may also be defined in terms of a process that includes all of the years of change due to fluctuating and declining hormones related to menopause. This definition includes the stages of perimenopause and early postmenopause.[13]

Perimenopause

Perimenopause precedes menopause and usually begins with irregularity in menstrual cycles and/or irregularity in duration and amount of menses blood flow.[6] Perimenopause is a significant stage because the physical and emotional changes that are associated with menopause begin in these 10 or even 15 years prior to the actual cessation of menstruation.[18] With approximately 25% of women experiencing the onset of perimenopause before the age of 43,[6] many women in their late 30's and early 40's are caught off guard, unaware that menopausal changes related to hormone fluctuations can begin so early in life. Heavy menstrual bleeding and/or severe hot flashes can seriously disrupt one's daily routine and sense of well-being,[6] particularly for those women who already suffer from premenstrual syndrome. Mansfield[18] noted the regrettable neglect in the literature concerning this particular stage, stating that many women believe the worst aspect of menopause is the lack of information and the uncertainty that surrounds the perimenopausal years.

Premenopause and Postmenopause

Premenopause refers to the years prior to any changes associated with perimenopause or menopause. Postmenopause is usually defined as the lack of a menstrual period for one year, the same definition used to denote menopause.[6]

Climacteric

The term climacteric is used interchangeably with the term menopause and includes the years of change surrounding the actual cessation, consisting of perimenopause, menopause, and early postmenopause.[16]

Etiology

Although there is a wide age range for onset of natural menopause, 39–59,[5] the median age is approximately 51.[1] **Etiology is not fully understood, but it is believed that natural menopause is precipitated by changes in hypothalamic function and depletion of the ovarian egg supply.**[16] This results in the loss of the female sex hormones, estrogen and progesterone, produced by the ovaries. Although other areas of the body continue to produce these hormones, the amount is minuscule compared to the prior ovarian source.[17-20] Certain physiological and psychological symptoms are associated with this change in hormone levels, but many other confounding variables make the identification of symptoms uniquely attributable to menopause a difficult task.[17]

Symptoms Associated with Menopause

The variety of symptoms that women experience related to menopause may be discussed from a variety of perspectives. Although the predominant explanations are provided by the biomedical model, cultural and psychosocial factors also have significant effects on how women experience and interpret menopausal symptoms.

BIOMEDICAL PERSPECTIVE:

There is significant variation in the number and severity of symptoms experienced by menopausal women. Although the majority of women report no problems, or only mild problems, some women experience sequelae that seriously disrupt their lives. Oldenhave and Netelenbos[6] reported that as women move from premenopause to perimenopause, there is a three-fold increase in reported symptoms such as joint pain, forgetfulness, worrying about their bodies, being constipated, and having dizzy spells. **The most common symptoms associated with menopause include: hot flashes, vaginal dryness, sleep disturbance, irritability, depression, anxiety, palpitations, headaches, fatigue, mental confusion, and forgetfulness.** [15,21-23]

Hot Flashes and Other Vasomotor Symptoms

Hot flashes, also known as hot flushes, belong to a category of symptoms known as vasomotor or autonomic nervous system symptoms and are described as **sudden sensations of heat in the face, neck, and chest. They may be accompanied by perspiration and/or shivering, and other vasomotor symptoms such as increased heart rate[24] and feelings of irritation, anxiety, or panic.[6] Night sweats, hot flashes that occur during sleep, have the irritating effect of disturbing sleep.[24] Women may be awakened many times during the night feeling hot, cold, or drenched with perspiration, and may be unaware that their disrupted sleep is due to hot flashes. Such sleep disturbance may result in fatigue and irritability.[22]** From a survey of 5,213 women aged 39–60, Oldenhave and Netelenbos[6] found that hot flashes or other vasomotor complaints were reported by 41% of women age 39 and over who were still experiencing regular cycles. By the onset of menopause, the percentage of women reporting hot flashes rose to 85%. Thirty percent of women close to menopause characterized their hot flashes as severe. Frequent flushes have a profound effect on the quality of life because they are associated with complaints such as tenseness, tiredness, irritability, headaches, muscle and joint pain, and depression.[6] **Hot flashes are the most common reason for menopausal women seeking medical attention[24] and the most common reason for doctors prescribing hormone replacement therapy.[22]**

Vaginal Dryness

Vaginal dryness, another symptom associated with menopause, is reported by 16% of regularly menstruating women aged 39. This percentage increases to 40%–45% of women who are 4–10 years postmenopause.[25] **Vaginal dryness is linked to a decrease in sexual desire and enjoyment, as well as difficulty with orgasm due to pain and discomfort.** Estrogen has been successful in diminishing or relieving vaginal dryness, but Mansfield et al.[14] point out that problems with sexuality **may be more complex than purely biomedical issues.**

Psychological Distress

Years of research that focused on the relationship between menopause and mental health have yielded conflicting and confusing results. Pearce et al.,[15] in a review of psychological symptoms in menopause, found several well-designed studies that demonstrated a slight increase in depressive mood during perimenopause. Three prospective studies, as well as several large cross-sectional studies of general populations, showed no significant increase. However, surveys of clinic populations showed considerable psychological morbidity.[26,27] **There are indications that the help-seeking subgroup of menopausal women report substantially more troublesome symptoms than the general population of women in menopause.** Anderson et al.[26] found that of those women seeking medical consultation for menopausal symptoms, 79% had physical symptoms and 65% had varying degrees of depression. One criticism of the available research on menopause is that although clinic populations are not representative of the general population of menopausal women, they have been used to define the menopause experience. However, understanding the profile of help-seeking women is beneficial for rehabilitation counselors.

There are many theories about the etiology of psychological problems during menopause. Matthews[18] suggests that if there is a slight increase in depressive symptoms in perimenopause, it may be attributable to women experiencing vasomotor symptoms for the first time. It was also noted that the depressive symptoms appear to subside as women adjust to these occurrences. Formanek[28] spoke of a climacteric vulnerability that decreases a woman's ability to cope with the many stressful events of this mid-life time, suggesting that factors other than the biophysiological contribute to symptomatology.

CULTURAL PERSPECTIVE:

The relationship between the dominant cultural paradigm of menopause and the experiences of women is emphasized by Bowles.[29] She theorized that a causative pathway which begins with cultural attitudes and beliefs, leads to personal attitudes and expectations, and ultimately influences how a woman actually experiences menopause. Several well-designed studies[30-31] have shown a positive correlation between negative beliefs and negative experiences. Cross-cultural research provides some of the best evidence of this link. For example, in cultures where aging women are afforded an elevation in status, such as in certain parts of India, Southern Africa, and in some Native American tribes, there are few problematic symptoms experienced with menopause.[32-34]

American culture tends to base a woman's worth on her sexuality, attractiveness, youth, and ability to bear children.[32,35] These qualities come under suspicion at menopause. Historically, cultural stereotypes, supported by the biomedical model, have portrayed climacteric women as old, useless, disease ridden, and emotionally unstable.[36-37] Such cultural ageism and sexism contribute to the following perceptions among women: associating no sense of achievement or gained status with menopause[38]; fear of physical and sexual deterioration;[14,37] and anticipation of depression.[18] Matthews[18] reported that 80% of the premenopausal women who participated in the Healthy Women Study believed that women in general were liable to get depressed during menopause. Fifty-five percent believed they themselves were liable to experience depression during menopause.

American women do not want to age. Rossi[39] found no mid-life woman who wanted to be older than she was, and half wanted to be under thirty. Younger women consistently view menopause more negatively than menopausal and postmenopausal women. Gannon and Ekstrom[41] suggest that because menopause is probably not of major concern to them yet, their attitudes reflect the dominant cultural perspective. Women in mid-life reveal concerns about body image, as they seek to reconcile cultural images of what women's bodies should look like with the changes they are experiencing.[32,39] Numerous studies have cited the serious lack of positive images of aging women.[8]

PSYCHOSOCIAL PERSPECTIVE:

Menopause is only one of many changes that occur in mid-life, a time when there is a shift in roles, responsibilities, and relationships.[42] Large epidemiological studies in the United States and Great Britain[43-45] support the belief that psychosocial stressors and symptomatology are related.[32] Carolan[32] emphasized the adverse effects of stressful mid-life circumstances (e.g., ailing husbands, widowhood, caring for elderly parents, divorce, loss of employment, coping with adolescent children, and health factors) on symptomatology.

Loss is a prominent theme of mid-life. During this time, women may deal first with loss of youth,[46] loss of procreative and parenting roles, loss of status, and loss of economic security.[34] Cook and Greene[47] found that the loss of significant others was the primary stressful life event associated with psychological symptomatology in menopause. Psychosocial and cultural factors may be stronger determinants of psychological and somatic symptoms than are biological factors. The interrelated nature of such various factors emphasizes the need for an integrative perspective.

Treatment of Menopause

The paradigm used to conceptualize menopause strongly influences the treatment modality. The dominant biomedical model defines the climacteric as a deficiency disease and treats it accordingly with hormone replacement therapy (HRT). Although this approach has been helpful to women, a treatment approach that considers biomedical, cultural, and psychosocial factors provides a broader-based plan that best reflects the complex nature of this mid-life transition.

TRADITIONAL MEDICINE AND HORMONE REPLACEMENT THERAPY:

Menopause is now defined as a deficiency disease and hormone replacement therapy (HRT) is being prescribed for millions of American women.[48] Even though we are still years away from definitive research on the benefits and risks of such therapy, hormone replacement treatments constitute a billion-dollar-a-year industry. Definitive studies have been lacking in women's health issues because research historically has been based on the male population, with results extrapolated to women.[49] Shortly after Dr. Bernadine Healy was appointed director of the National Institute of Health in 1991, she launched the NIH Women's Health Initiative, an extensive study of women's health issues.[49] This promises to be "the most sweeping study of women's health problems ever attempted, with hundreds of thousands of women participating in research expected to cost $500 million over 10 years."[49] Included in this study are components that examine the effects of estrogen and progesterone on the overall health of women. Definitive results are not expected before the year 2000.[49]

The term HRT usually refers to a regimen of unopposed estrogen, meaning without progesterone, for menopausal women who have had hysterectomies, and estrogen plus progesterone for those who have not. Sometimes testosterone, a male hormone, is also added for women who complain of decreased libido.[1,50] **Hormone replacement therapy is prescribed for two major purposes: the relief of climacteric symptoms and prevention or postponement of osteoporosis and heart disease. It is estimated that 40% of American women who are menopausal and postmenopausal use HRT.[48]** However, studies show that up to 50% of women discontinue its use within the first year, citing the fear of cancer and displeasure with bleeding as major factors.[1,51] A Gallop survey done in 1993 of 833 women aged 45–60 showed that women believed their doctors had failed to supply adequate information about such things as long-term effects of estrogen deficiency, treatment options, and possible side effects of HRT.[52]

ESTROGEN AND PROGESTERONE:

Estrogen refers to a general class of hormones which includes the closely related substances estradiol, estrone, and estriol.[20] It is believed that as levels of estrogen in blood and tissue drop, the troublesome vasomotor and musculoskeletal symptoms may appear.[19] In premenopause, 95% of the estrogen is secreted by the ovaries and is in the form of estradiol. During menopause, estrogen levels drop dramatically as the ovaries end their production. After menopause, estrogen, in much smaller amounts and in the weaker form of estrone, continues to be manufactured in the fat cells.[5,23]

Estrogen replacement is recognized to be effective in reducing or relieving hot flashes, sleep disturbances, irritability, and vaginal dryness in menopausal women.[13,25] However, unopposed estrogen significantly increases the risk of uterine cancer for those women who have not had a hysterectomy. Stimulated by estrogen, the lining of the uterus proliferates and often undergoes changes called hyperplasia.[22] For some women, this develops into cancer. The addition of progesterone preserves the integrity of the uterine lining and reduces the risk of uterine cancer to that of non-hormone users.[22] Unfortunately, the addition of progesterone may cause the return of monthly bleeding and the symptoms associated with it.

Freedom from monthly periods is cited by many women as the best aspect of menopause,[38] making a return to bleeding and cramps unacceptable. Between 10% and 50% of women who discontinue HRT stop because of bleeding.[22,51] A regimen of progesterone therapy is now used that protects the uterine lining without inducing monthly bleeding.[53]

There are many available types of natural and synthetic estrogens, progestins (synthetic progesterone), and natural progesterone. Women have choices of different routes of administration, such as oral, vaginal, transdermal, or implant; different types of estrogen and progestins/progesterone; and different combinations and strengths.[5,20,53] Because responses to these hormones are very individualized, a trial-and-error approach may be needed in order to find the combination that works best.[53]

As discussed earlier, HRT is believed to be effective in reducing or relieving vasomotor symptoms and vaginal dryness and to have protective qualities against certain diseases. Studies suggest that HRT may also improve psychological[54] and cognitive[55] functions.

Disease Prevention

The second major purpose for prescribing HRT is that of disease prevention, particularly of osteoporosis and heart disease. Osteoporosis, a condition in which the bones lose significant mass, often results in fractures. It is estimated that one in three American women will develop some complication of osteoporosis. Seventy-five percent of the bone loss that occurs within the first 20 years postmenopausally is attributable to estrogen deficiency.[16] Postmenopausally, osteoporosis causes 1.3 million fractures a year. Most of the 120,000 yearly hip fractures occurring in women over 45 are due to this disease and will result in 15% of the victims dying within one year of the break.[25] Seventy-five percent of them will lose their independence and 25% will require long-term skilled care. Between 7 and 10 billion dollars are spent each year on the complications of osteoporosis.[19]

Studies consistently support the effectiveness of HRT in preventing or retarding osteoporosis.[6,18,56] As early as 1975, a 10-year prospective study of the effects of estrogen and progesterone on osteoporosis showed that if HRT was instituted within three years of menopause, the loss of bone mass could be reversed, and if started after 3 years it could at least be halted.[37] Because benefits of HRT are quickly lost once treatment is stopped, some doctors recommend maintaining therapy for 10 years, if not indefinitely.[22]

Coronary heart disease (CHD) is the leading cause of death among postmenopausal women, claiming approximately 250,000 lives each year and accounting for at least 1/3 of age-related deaths.[16,22] A review of literature found overwhelming support that estrogen reduced the risk of CHD.[16] A meta-analysis of observational studies suggests as high as a 50% reduced risk in postmenopausal women taking estrogen.[38] **The National Institute of Health's** (NIH) **Postmenopausal Estrogen/Progesterone Intervention trial** (PEPI), **a 3-year landmark study, researched the effects of adding progesterone to the hormone regimen and concluded that unopposed estrogen provides the best cardiovascular protection, but the protection afforded by estrogen/progesterone is similar.[58]**

Risks

In light of the well-accepted benefits of HRT, the major complicating factor for women is the risk of breast cancer. Breast cancer kills an estimated 46,000 women each year.[16] Once again, research has yielded conflicting results. In 1995, within two months of each other, two major medical journals reported studies finding opposite results.[22] *The Journal of the American Medical Association* published an article with findings from a population-based, case-control study of women aged 50–64, involving 537 patients with primary breast cancer and a control group of 492 randomly selected without a history of breast cancer. They concluded that estrogen and progesterone did not appear to be associated with an increased risk of breast cancer in middle-aged women.[11] *The New England Journal of Medicine* published results from a follow-up of the Nurses' Health Study, a prospective cohort study, that looked at 725,550 women and concluded just the opposite.[9] Although they found a small but significantly increased risk of breast cancer in women using unopposed estrogen or estrogen with progesterone, they noted the increased risk was found particularly in women who had taken HRT for five or more years. An earlier meta-analysis of the effects of estrogen on the risks of breast cancer also concluded that risk did not appear to increase until after five years of use.[39]

ALTERNATIVE TREATMENTS:

Some women are turning to plant sources, such as the soy bean, for natural estrogens (phytoestrogens).[60] The Soy Estrogen Alternate Study, under the auspices of NIH, is presently underway at Bowman Gray School of Medicine (B.Earl, RN, personal communication, February 9,1997). Natural progesterone, derived from the South American yam, is being marketed in topical cream forms.[20,61] Micronized progesterone, a natural progesterone that can be taken orally and causes fewer side effects than the popular synthetic progestins, is also gaining in popularity and is being prescribed by medical doctors.[48] **The naturopathic view is that natural hormone sources, proper diet, exercise, vitamins, herbs, and minerals can provide helpful supplementation or alternatives to traditional medical treatments.[20,23,53,62] Definitive research that addresses these claims is not yet available.** Love[33] suggests that women considering alternative treatments can do preliminary research by reading and talking with knowledgeable friends, but that

before beginning use they should see a qualified practitioner of these methods.

Women still await definitive research that can guide their choices for coping with the changes of menopause. The NIH Women's Health Initiative will hopefully yield results on the long-term effects of HRT early in the 21st century.[3] Until then, women will have to weigh the benefits and risks, considering their own symptoms, health status, family history, and personal preferences, as they, in collaboration with their health care providers, decide the best course of action.

An Integrative Perspective

Defining menopause in terms of disease disqualifies it as a normal life transition.[32] However, denying the impact of biomedical factors ignores the reality of physiological change, possible disruptive symptomatology, and health risks. One value of an integrative perspective, which combines paradigms from both biomedical and behavioral sciences, is the ability to reframe negative medical issues in contextually more positive terms. There is great variability in the experience of menopause, pointing to the need for flexibility and breadth in definition, research, and services.[32] It is the combination of paradigms which provides a broad-based multidimensional perspective on menopause, one which allows counselors to appreciate each woman as both similar to and different from other women in this time of change. An integrative perspective, as feminists suggest, may describe biomedical conditions and psychosocial turmoil in developmental terms, as part of a normal and expected transition.[33] **This approach engenders responsibility and empowerment, as it returns to women a sense of control over their bodies and lives.** It also encourages healthy living, good nutrition, proper exercise, decrease in over-medication, and complete information on the risks and benefits of HRT.[32]

Implications for Rehabilitation Counseling

Although issues related to menopause are not typically part of the rehabilitation counselor's repertoire, we advocate that these concerns be included in the rehabilitation process. Greenfield and Wolfe[33] noted the importance of conceptualizing premenstrual syndrome (PMS), a factor also present during the menopause transition, as a potentially disabling condition. Their conclusion was that rehabilitation counselors need to "help PMS sufferers by developing treatment plans which account for the disability and its impact upon the person's ability to function within the family setting and the job locations." Similarly, the factors related to menopause discussed here affect the mid-life woman's ability to function within these settings. Because the majority of women do not experience severe symptomatology, and because of the minimalist view that menopause is uneventful,[32] women who struggle with this transition carry the additional burden of being outside of the norm. **Rehabilitation counselors can help their clients understand that severe symptomatology is experienced by many women, and although it is part of a normal life transition, its disruptive symptoms are far from "normal" or uneventful. There are many treatment options and coping strategies that must be considered in order for women to cope successfully with their personal, social, and work-related lives.**

At present, because symptoms related to PMS and menopause are not included in the DSM-IV, third party payers may be reluctant to include treatment for these conditions as reimbursable services. Most often, however, women presenting to rehabilitation counselors will have other conditions as their primary disability, conditions which will likely be exacerbated by the symptoms of menopause. An understanding of these symptoms is important for all rehabilitation counselors.

Mansfield et al.[17] revealed a reluctance of health care providers to discuss menopause. This may be due to a remaining cultural stigma attached to menopause, or to a lack of knowledge and understanding about the issues. **Rehabilitation counselors need to be knowledgeable about and comfortable with the topic in order to meet the needs of female clients.**

Designing a Personal Approach

Clients initially may present with menopausal symptoms, or with preexisting disabilities for which menopause presents additional biological and psychosocial bases for disability. Using an integrative approach, rehabilitation

counselors can help clients understand the multidimensional aspects of the climacteric.

Framing menopause conceptually as both normal and transitory helps women cope with disruptive symptoms, perceived loss of control, and fear of the unknown. Counselors can help clients plan and implement an approach to this mid-life process that engenders a sense of control and empowerment, while setting a positive stage for the next trimester of life.

The following is a seven phase guide that rehabilitation counselors may find helpful when working with menopausal women who have preexisting disabling conditions, or with those who present for the first time with menopausal complaints. This guide is not meant to be a rigid chronological process, but rather a framework that reflects the multiple and complex aspects of menopause. Phases may be blended or rearranged according to client needs and time restraints. The purpose of the guide is to assist clients in defining, understanding, and responding to their own unique experiences of the climacteric.

PHASE ONE—EDUCATION:

Because meaning is ascribed to experiences based on available information, counselors can educate clients by providing accurate, unbiased information that is representative of the complex nature of menopause.[58] **As counselors listen to clients for insight into how they perceive and respond to menopause, counselors can raise questions that call attention to misconceptions and misinformation.** Sharing of information and increasing awareness comprise the first phase of this process.

PHASE TWO—COMPLETE MEDICAL EVALUATION:

Initially, clients need to see their medical health care provider for a complete evaluation to rule out co-existing pathology, determine the status of physical and emotional health, and review any current medications and treatments. At this time menopause can be discussed from a biomedical perspective that provides accurate information and treatment recommendations. Rehabilitation counselors can encourage women to choose health care professionals who are comfortable co-creating a health plan, a professional with whom the client can dialogue.

PHASE THREE—SELF-ASSESSMENT:

The client is encouraged to begin a menopause self-assessment by considering the context and impact of biomedical, cultural, and psychosocial factors:

- **How have sociocultural attitudes about aging and menopause affected my attitudes?**
- **What are my expectations and fears about menopause?**
- **What are my most immediate needs and concerns?**
- **What symptoms have I noticed that may be related to perimenopause or menopause?**
- **How are my menopausal symptoms interacting with any preexisting disabilities?**
- **How healthy is my lifestyle in terms of diet, exercise, smoking, excessive alcohol intake, abuse of over-the -counter or other drugs and medications?**
- **What is my family medical history in terms of osteoporosis, heart disease, and breast cancer?**
- **What are the major stressors in my life?**
- **What can be done to reduce the stress?**
- **How much thought and effort have I put into taking care of myself lately?**
- **What are my information gaps about menopause?**

PHASE FOUR—DIALOGUE AND DEFINITION:

Women need support, encouragement, and someone to talk to about menopause.[12] As Gilligan[64] reminds us, women define themselves in relation to others. Because normative experiences of mid-life menopausal women are lacking, women can define what is normal for themselves as they interact with their families and other women. Rehabilitation counselors can facilitate this by providing one-to-one counseling and by developing support groups and other interactive experiences. Conceptualizing menopause as a mid-life transition provides

opportunities to reframe perceived endings and losses in terms of new beginnings. Questions for women to consider in this phase include:

- **Who are my support people who will listen to me, speak with me, and help me make sense of my experience?**
- **What are other women thinking and experiencing who are at the same stage in life?**
- **What are the realities of my own experience? What help do I need?**
- **How can I conceptualize menopause as a transition time of growth and exploration?**
- **How would I like my life to change during this mid-life transition?**
- **How can I make it happen?**
- **How can I integrate biomedical aspects with this expanded model?**
- **How do I define menopause? How do I define myself as a mid-life menopausal woman?**

PHASE FIVE—UTILIZING RESOURCES AND CREATING A PLAN:

It is important to explore with clients their power to choreograph their own response to menopause. **Rehabilitation counselors can encourage clients to become empowered through knowledge of resources and options. Sources of information that include both alternative and traditional medicine broaden treatment options. Natural health and nutrition stores have an abundance of information, as do book stores and libraries. For those who have access to this resource, the North American Menopause Society and other excellent resources can be found on the World Wide Web (WWW.MENOPAUSE.ORG./NEWS.HTML).**

Rehabilitation counselors can encourage women to **develop a personal plan for the climacteric** that is broader than a biomedical perspective. The plan can include practical solution-oriented interventions, such as ways to cope with disrupted sleep patterns or with weight maintenance, as well as more abstract components such as scheduled time to reflect, redefine, and plan for the future.

PHASE SIX—IMPLEMENTING THE PLAN:

Women can be empowered by assuming responsibility for implementing their plans. Counselors can remind clients to be patient with themselves, to implement changes by degrees, and to seek a partner or group with whom to share their experiences. If clients experience troublesome physiological symptoms, counselors can encourage clients to contact their medical health care provider for assistance. The responses of women to menopause and hormone therapy vary dramatically and often require a trial-and-error approach to find the best combination of hormones.[33] Counselors can encourage women to be assertive and to collaborate with their medical team until satisfactory results are obtained.

PHASE SEVEN—REEVALUATION AND ADJUSTMENTS:

In phase seven, counselors remind clients that menopause is characterized by variability and change. Rehabilitation counselors can help normalize symptomatology and remind clients of the "trial and error" approach to coping. Priorities and circumstances change as women move through menopause, requiring updating and adjustment of the plan. For example, disruptive symptoms may subside and issues of changing roles may become the emphasis. Counselors must also be sensitive to the wide variations in how women experience menopause. It is helpful to remind clients who struggle with severe symptoms that menopause is a transition, meaning it will end. Until then, creativity, support, and encouragement are critical.

Conclusion

Menopause is a normative female mid-life transition that remains poorly understood in terms of definition, normative experience, and treatment. Although most menopausal women do not report serious problems with menopause, a subset of help-seeking women do, and for these women, menopause can be defined as a disability.

Rehabilitation counseling can provide women with accurate information while acknowledging the complex

interaction of biomedical, cultural, and psychosocial factors. Women can experience social and emotional support, become better informed, receive assistance in dealing with stressful life situations, and receive guidance for developing their personal approaches to coping with menopause. The rehabilitation counselor can help each woman to make sense of her own unique experience with menopause and to develop coping strategies for her particular disruptive symptoms. The counselor should stress the understanding that this transition is a prerequisite to an additional adult lifetime yet to be lived. This model embodies the philosophy of rehabilitation counseling; it empowers the individual woman to risk, grow, and improve her quality of life.[65]

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

9. Which of the following is *not* correct?

A. Perimenopause precedes menopause and usually begins with irregularity in menstrual cycles and/or irregularity in duration and amount of menses blood flow

B. The most commonly accepted definition of menopause states that menses must have ceased for at least one year.

C. The term climacteric is used interchangeably with the term postmenopause and includes the years after menses has ceased.

D. It is believed that natural menopause is precipitated by changes in hypothalamic function and depletion of the ovarian egg supply.

10. Which of the following statements is/are correct?

I. Defining menopause only from a psychosocial perspective may minimizes the reality of physiological change, possible disruptive symptomatology, and health risks.

II. A biomedical approach to understanding menopause returns to women a sense of control over their bodies and lives.

III. An integrative perspective on menopause, which combines paradigms from both biomedical and behavioral sciences, facilitates reframing negative medical issues in contextually more positive terms.

A. I and II

B. I and III

C. II only

D. III only

11. Which of the following is *not* correct:

A. Hot flashes are the most common reason for menopausal women seeking medical attention and the most common reason for doctors prescribing hormone replacement therapy.

B. The naturopathic view of treatment of menopause holds that natural hormone sources, proper diet, exercise, vitamins, herbs, and minerals can provide helpful supplementation or alternatives to traditional medical treatment.

C. Vaginal dryness is linked to a decrease in sexual desire and enjoyment, as well as difficulty with orgasm due to pain and discomfort.

D. There is little support for the claim that estrogen reduced the risk of coronary heart disease in menopausal women.

12. Which of the following statements is/are correct?

I. Hormone replacement therapy is prescribed for two main purposes: the relief of climacteric symptoms and for the prevention of disease, particularly osteoporosis and heart disease.

II. The major complicating factor of HRT is the risk of breast cancer.

III. Estrogen replacement is recognized to be effective in reducing or relieving hot flashes, sleep disturbances, irritability, and vaginal dryness in menopausal women.

A. I only

B. I and III

C. I, II, and III

D. None are correct.

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Directions in Rehabilitation Counseling

Volume 9 Lesson 4

Utilizing Community Resources in the Rehabilitation Process

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Introduction

When an agency accepts a consumer for service and assignment is made to a particular professional, that agency is actually assuming responsibility for the "whole person." A person seeking help in finding a job from a vocational rehabilitation agency may need many other services in the process. These services, which include medical restoration, education, and mental health counseling, are often outside the scope of the skills or responsibilities of the professional to whom the consumer was assigned. Vandergoot and Jacobsen state:

> A basic problem for many counselors is having enough time and resources to meet service expectations. Large caseloads and varied service needs often force counselors to decide on service priorities which exclude the needs of some clients. In situations like these, consumers, through their original agency, should use outside community resources.[1(p99)]

This lesson is a discussion of the use of community resources in the practice of vocational rehabilitation. It shows how counselors can systematically identify, select, and use community resources in their case practices. The advantages of using community resources include improved service for consumers, increased openness and public awareness, the elimination of duplicative service efforts, and, for counselors in federal programs, the satisfaction of congressional expectations.[2]

Types of Community Resources

Crimando[2(p7)] defines community resources as any service vendors—public or private, fee-charging or not—available within a specific geographic area that potentially can be used to aid consumers, counselors, or orga-

nizations. Although broad, this definition implies that community resources must (*a*) be capable of providing a needed service or commodity; (*b*) be willing to enter into a relationship in which those services and commodities can be purchased or otherwise secured; (*c*) be located in a place that is geographically accessible; and (*d*) have eligibility requirements that counselors or consumers can meet. This suggests that "community" and "resource" take on different meanings relative to the needs and abilities of consumers. A community could be as small as a city block or as large as the entire nation, depending on the availability of a particular agency's services or commodities. Vandergoot and Jacobsen[4] define communities as groups of people living in a common area, interacting in many ways, such as exchanging goods, services, and information. **By contrast, Seider[5] suggests that communities are not limited by geographic boundaries, but are composed of interconnected social systems and institutions; this encompasses contemporary "cyberspace communities."**[6] The meaning of "resource" may vary as well; "if we serve a caseload of indigent families, from our perspective a neighborhood grocer who is willing to give away day-old baked goods and produce is a resource, while a college placement office that only serves students may not be."[7]

Community resources can be categorized as either single-service or multiple-service agencies. Single-service agencies, such as physicians, legal clinics, financial counselors, and transportation vendors (e.g., cab companies and bus lines), provide only one type of service. Multiple-service agencies provide services of two or more types. These agencies include community colleges, which often provide vocational and psychological guidance as well as educational services; comprehensive community rehabilitation programs from which job training, adult basic education, vocational evaluation, and placement services could be secured; and Public Aid, which serves a variety of physical, financial, and vocational needs.

Single-service agencies have several potential advantages for the case manager. Because they can focus on a single mission, they are more likely to provide high-quality services, and they can hire specifically trained professional staff that is likely to stay up-to-date in their skills. Multiple-service agencies, on the other hand, can potentially view a consumer's needs from multiple perspectives. They make it unnecessary to develop separate and possibly redundant formal service agreements with multiple single-service vendors.

Crimando and Riggar[8] identify seven categories of community resources:

1. **Health and diagnostic services.** These programs provide diagnostic, restorative, and therapeutic medical and psychological services, such as hospitals, mental health centers, and substance abuse programs.

2. **Social services.** These programs provide family, financial, and protective services, such as Social Security, Children and Family Services, and Family Planning.

3. **Legal services.** These programs—including Legal Aid, the Equal Employment Opportunity Commission, and Guardianship and Advocacy—were designed to help individuals in protecting their legal and civil rights and in seeking recourse when those rights may have been violated.

4. **Vocational and employment services.** These programs offer assistance in identifying and seeking appropriate employment and employment training. They include Job Training Partnership programs and the United States Employment Service.

5. **Rehabilitation services.** Primarily serving people with disabilities, these vendors provide case management, vocational services, diagnostic and therapeutic services, and a wide range of other services, depending on the vendor. Included in this category are the State-Federal Vocational Rehabilitation Program (serving those with the most severe disabilities), Community Rehabilitation Programs, Rehabilitation Engineering Centers, and Technology Assistance Programs.

6. **Educational services.** This comprises colleges and universities, special education programs, training schools, and other entities providing education and training to the general population as well as to persons with special needs.

7 **Human services. These are miscellaneous services such as housing, community disaster programs, and financial counseling.**

Using the categories suggested by Crimando and Riggar,[3] Table 1 is a comprehensive, though not exhaustive, list of community resources used by rehabilitation professionals.

Identifying and Selecting Community Resources

Sheafor, Horejsi, and Horejsi[4] insist that in order to make effective referrals to community resources, those in the case manager's role must thoroughly understand existing community resources. They must invest considerable time and energy keeping up with changing community resource systems and the needs of their consumers. **The steps in systematically identifying, selecting, and using community resources are (*a*) needs assessment, (*b*) potential resource identification, (*c*) resource selection, (*d*) referral, and (*e*) monitoring.**

NEEDS ASSESSMENT:

Needs assessment is the collection, analysis, and synthesis of data regarding the needs of a person or organizational entity, such as a caseload, a group, or an entire organization. Needs are usually defined in terms of discrepancies between current levels and ideal outcome levels.[5] Assessing needs in case management involves identifying the discrepancy between consumer needs and the capacity of the consumer, the consumer's social network, and the provider network to meet those needs.[6]

Caseload needs may include three types, which often overlap: consumer needs, counselor needs (personal and professional), **and organizational needs.** Consumer needs are the requirements for survival, security, love and esteem, and growth. These translate to the basics—food, clothing, shelter, health, employment, and so on. Most agencies set limits on the provision of service needs; for example, the state-federal rehabilitation system will only meet service needs required to achieve employment outcomes for persons with severe disabilities. Each state agency may further restrict service provision through budget policies.

Professional counselor and organizational needs, though often overlooked, are equally important. Counselors and other professionals may have knowledge and skills deficits, require emotional support to continue in difficult situations, or merely need another professional

Table 1
COMMUNITY RESOURCES

Health and Diagnostic Services
Private physicians, dentists, etc.
Specialized hospitals
Home health services
Community mental health
Pain clinics
Alcohol-drug programs
Peer self-help groups

Social Services
Social Security
Public Aid
Medicaid
Children and Family Services
Women's centers
Family Planning

Legal Services and Advocacy
Legal Aid and public interest advocacy
Equal Employment Opportunity Commission
Civil rights
Guardianship and Advocacy
Client assistance programs

Education
Vocational education
Adult education
Special education

Vocational and Employment Services
Employment security — Job Service
Job Training Partnership Act
Private employment services
Supported employment
Projects with industries

Rehabilitation Services
Vocational rehabilitation
Community rehabilitation programs
Private rehabilitation
Work-hardening centers
Rehabilitation engineering centers
Technology assistance programs
Job Accommodation Network

Human Services
Centers for Independent Living
Financial assistance/counseling
Housing
Community service organizations
Private vendors of clothing, food, technology, etc.
Automobile, van modifiers
Personal care assistance

to discuss new techniques or critical cases. Counselors' needs revolve around their desire to be as effective as possible. Similarly, organizations have effectiveness needs, which include funding, referrals, public relations, and community support. Frequently these needs are already being met through consumer, professional, or organizational assets or through existing service agreements with other community agencies. The formal and informal relationships both within and outside the agency should be examined to detect unmet needs.

During intake, eligibility determination, or the beginning stages of a counseling relationship, the fact finding in which the counselor and consumer engage—uncovering strengths and weaknesses of the consumer—constitutes a form of needs assessment. There are several other times when an organization or a counselor might wish to assess needs systematically:

- **A counselor who is assigned the case of a consumer with a disability with which the counselor is unfamiliar may need to do an expanded needs assessment to become familiar with potential problems and available vendors.**
- **A counselor who "inherits" a caseload from another counselor can use needs assessment to identify patterns of unmet needs.**
- **A new rehabilitation organization/agency, or an existing agency undergoing a change in their mission, may benefit from a comprehensive needs assessment such as a resource inventory[5] before "positioning" itself, that is, finding a strategic niche in which to operate.**
- **An existing organization or agency implementing a comprehensive program evaluation or embarking on a continuous improvement endeavor should do a needs assessment such as a use analysis.[6,7]**

Both unmet and met needs can be determined through a number of sources: (*a*) interviews with consumers, (*b*) interviews with other counselors in the agency and collateral agencies, (*c*) diagnostic protocols and referrals, (*d*) caseload reviews, (*e*) reviews of existing interagency service agreements, and (*f*) self-examination of professional needs and assets.

POTENTIAL RESOURCE IDENTIFICATION:

Once needs have been determined, outside resources that could potentially fill those needs should be identified. At this step, the counselor should find as many potential vendors as possible, so that the most efficient and effective decisions can be made.

The counselor may utilize both formal and informal sources of information about potential resources. Formal sources include all printed or published materials about community agencies, such as community assistance directories, information and referral network/databases, telephone books, procedures manuals, and the other public relations materials that individual agencies publish. Disability advocacy groups and community rehabilitation facility associations may also publish similar documents. In addition, community rehabilitation facilities and other vendors may have their own sites on the World Wide Web (WWW). Notable examples are the Job Accommodation Network,[10] Evan Kemp Associates,[11] and the Chicago Association for Retarded Citizens.[12] Counselors can locate web references to community resources through such online sources as the Library of Congress and Human Services Online.[13]

Informal sources comprise any sources other than published (or web) material. They may include other counselors, supervisors, or professionals—within one's own agency or outside—that form one's professional network. A well-cultivated network will offer a wealth of information, and this information will likely include contacts and tactics for working through bureaucracies.

Reviewing files from a variety of caseloads provides additional information. Both referral sources and past vendors are potential resources. Counselors can make personal visits to other agencies and can invite representatives from those agencies to visit. This may be fruitful in both gathering information and expanding professional networks. Colleagues or members of professional organizations, such as the American Rehabilitation Counseling Association or the National Association of Rehabilitation Professionals in the Private Sector, may be able to provide leads. Finally, consumers' friends, relatives, and acquaintances may be of assistance.

Table 2 is a list of generic questions that may be considered when examining potential resources. Other ques-

tions may arise with regard to specific vendors. For example, in brain-injury rehabilitation, questions such as these may arise[5]:

- Does the evaluation include a projected discharge living status (e.g., independent, group home, nursing home, parent's home)?
- Does the program employ a neuropsychology staff?
- Is the program setting consistent with the consumer's pre-injury lifestyle?

RESOURCE SELECTION:

Having identified needs and potential resources, counselors must select the most appropriate resources. Selecting the "best" resource requires problem-solving skills and a good decision-making strategy. Two decision strategies have been suggested: optimizing and "satisficing."

Optimizing

This is the examination of as many alternatives as possible to find the most beneficial. McCollum, Swenson, and Hooge[6] and Vandergoot and Jacobsen[7] suggest that optimization is desirable in the selection of community resources; Lewis and Lewis[8] believe it is important to try to optimize in any human service planning endeavor.

To optimize, one first selects a number of criteria (perhaps from Table 2) **that are most important in resources for a specific consumer need; criteria may be weighted by their relative importance to the consumer and counselor.** Next, a range of alternative resources are identified through "brainstorming." All of these alternatives are then rated or scored on their ability to meet the selected criteria, with different values assigned to "does not meet," "partially meets," "meets," and "unknown" states. An overall score is arrived at by summing across criterion scores after they have been adjusted according to their weights. The resource receiving the highest score is chosen. Presumably, this will be done for each specific consumer need.

Table 2
POTENTIAL SELECTION CRITERIA FOR COMMUNITY RESOURCES

General
What is the purpose of the program/agency/organization?
Who is eligible to receive services?
What organizational patterns exist?
What is the nature of funding?
What constraints in service provision does the organization face?
Does the organization have appropriate accreditations?

Services
What services are provided?
Are services available to families?
Are case management services provided?
What emergency services are offered?
What linkages or service agreements does the organization have with others to meet special needs?

Staff Composition
What is the size of the staff?
What is the average caseload size or staff-to-client ratio?
What are the qualifications of the staff?
Do staff members possess required/desired degrees, certifications, licenses, etc.?
What experience has the staff had in working with your specific population?

Resources
What facilities are available?
Are locations accessible to clients by a reliable mode of transportation?
If clients must be relocated, are essential/desirable living or support resources available?
Are program facilities accessible to clients?
What equipment (e.g., testing, therapy, training apparatus) is available?

Referral/Utilization
How should referrals be made?
How many people is the agency capable of serving at the same time?
Is there a waiting list? How long is it?
Are regular, meaningful reports issued for clients?

Program Planning
Is there a minimum/maximum length of program?
What postdischarge or follow-up services are provided or available?
Are programs tailored to meet individual consumer needs?
Is consumer or family input considered in program planning?

Cost
What is the cost per consumer day in the program?
What is the rate/pricing structure (e.g., uniform, cost reimbursement, cost plus fee)?
What discounts are available?

Outcomes
Does organization have an acceptable number of successful outcomes (e.g., consumers placed, trainees graduated, clients detoxified)?
Is there a minimum of unsuccessful outcomes?
What attention is paid to the quality of successful outcomes?
Do outcomes match organizational goals and objectives?
Do outcomes match a reasonable professional standard?
Does the organization examine unsuccessful outcomes thoroughly?

Consumer/Public Relations
What is the reputation of the program in the community or among other professionals?
Are consumers satisfied with services?
Are consumer families satisfied with services?

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Although optimizing is ideal, the process is cumbersome for some decisions and redundant for others. Simon[18] suggests that people use a strategy he refers to as "satisficing," representing a compromise between the consideration of every conceivable alternative and the time and information constraints of such a strategy. In satisficing, a small number of "criteria of value" (criteria given a greater relative weight by the counselor or consumer) are established prior to identifying alternatives. Potential alternatives are then examined until one meeting all criteria of value is found, at which time the search stops. For example, in selecting training vendors for consumers with brain injury, a counselor might use "experience with the population" and "cost per consumer day," as well as a comprehensive list of services offered, as criteria of value; training alternatives would be examined one at a time until one meeting these criteria is found.

REFERRAL:

Although the reader may infer that the first three steps of identifying and selecting community resources are not done continually because of their time and labor intensiveness, making referrals to community resources is a frequent occurrence. In their study of rehabilitation counselor competencies, Wright, Leahy, and Shapson[19] found that items associated with managing the referral process dominate—in both quantity and importance—the case management function of rehabilitation counselors. Further, Greenwood[20] estimates that counselors need to devote at least 30 minutes following the intake interview alone to make necessary arrangements with referrals.

Irrespective of any ongoing service agreement with a vendor, the referral letter is the initiating point in the referral process. The most effective referral letter follows a phone call to a fellow member of a professional or organizational network. In such a case, the letter reiterates the important points discussed on the phone, clarifies details of service provision, and provides supplemental background information on the consumer that the vendor will need to offer effective service. **The effective referral establishes an often-necessary "paper trail," documenting the coordination of the referring counselor with the vendor.** If the fee mechanisms for the referring agency consist of service contracts or purchase-of-service agreements, the referral letter is the initiating document, specifying consumers, services to be provided, outcomes expected, timeliness, and so on.

All referral letters provide similar information, regardless of the vendor being contacted:

- **An introduction to the consumer. Background information relevant to the presenting problem, or needed by the vendor in order to effectively serve the consumer, is critical. Clinical impressions and concerns are particularly helpful. In presenting this type of information, care needs to be taken to uphold the policy of the referring agency on release of consumer information.**

- **The specific services or products needed. These services** (e.g., diagnostic, therapeutic, restorative, or educational) **or products** (e.g., prosthetics, orthotics, or appliances) **should be identified. If the referral is for a diagnosis or an evaluation of some type, the questions in which the referring counselor is interested should be specified.**

- **The monitoring mechanism. Minimally, a monitoring mechanism that includes clearly stated goals and objectives should be identified. Terms for renegotiation of service costs, mechanisms for joint case planning, and quality assurance review procedures also may be discussed.**

- **Time lines. Dates by which the services are expected to be completed or renegotiated should be specified.**

- **Special considerations. A list of ancillary services needed by the consumer** (e.g., transportation from home, lodging, or case management) **should be detailed.**

In lieu of referral letters, many vendors develop referral forms that provide a structure for the kind of information they need to provide services, and some agencies use generic referral forms that can be used for any vendor. Figure 1 is an example of a generic referral form (see Appendix A, at the end of this lesson).

MONITORING:

Finally, to remain efficient and effective, a service delivery system—whether a single referral relationship or a comprehensive community network—needs continuous monitoring.

Raiff[9] and Shore[21] outline nine aspects of quality monitoring practice:

- **The case manager expends considerable effort, developing a relationship for free exchange of information, triangulating, and cross-checking data.**
- **A regular monitoring schedule is planned and implemented.**
- **Additional oversight is provided as needed.**
- **The case manager uses and is comfortable with aggregate and computer-generated reports.**
- **Consumers and caregivers are encouraged to become knowledgeable consumers in regard to rights and standards of practice.**
- **Consumers and caregivers are assisted in developing simple systems with which they can do their own monitoring.**
- **Measures of consumer satisfaction are routinely taken and used.**
- **There is considerable administrative support—in the form of time and resources—for program monitoring.**
- **All services are monitored, irrespective of the possibility to directly influence change.**

Although Table 2 can be used as a guide, counselors should pay particular attention to several points in monitoring community resources.

Outcome

Of primary significance in long-term service provision (e.g., training or education, physical rehabilitation, or psychological counseling) **is the consumer's satisfactory progress, or the vendor's ability to provide a sufficient explanation if it is unsatisfactory.** If the service is short-term (e.g., vocational evaluation, housing assistance, or financial counseling), the concern is that it was completed satisfactorily. If the vendor is providing a commodity or equipment (e.g., food or clothing), the questions are as follows: "Did the consumer receive the commodity?" and "Does it work as intended?" Finally, some vendors provide combinations of service and equipment: for example, prosthetic manufacturers and augmentative communication device manufacturers routinely provide training and maintenance. In these cases, outcome issues may include a combination of short-term, long-term, and commodities issues.

Responsiveness to Consumers' Primary and Special Needs

Clearly important is the vendor's performance in responding to the needs (services, evaluations, and special considerations) **outlined in the referral letter.** The vendor's openness to the input of the consumer and the family, as well as overall consumer/family satisfaction, should also be considered. **Satisfied consumers appear more likely to follow service plans, persevere in the rehabilitation process, and have improved outcomes.**[22]

Responsiveness to Referring Counselor's Needs

Similarly, referring counselors have needs for regular staffings; input on planning; useful, timely and accurate reports; and cooperation in cost containment when appropriate.

Responsiveness to Organization Needs

Finally, organizations have needs that must be satisfied, such as timely billing; gathering appropriate data for program evaluation; and satisfying legal, funding, or accreditation authorities. If both the purchasing organization and the vendor are part of a community referral network, the rate at which the latter is referring consumers to the former may also be considered.

Issues in Using Community Resources

THE ROLE OF CONSUMERISM AND INFORMED CHOICE:

Consumerism in rehabilitation counseling parallels the consumer movement in the private sector; as business and industry find ways to become more "cus-

tomer driven," rehabilitation agencies and organizations seek similar opportunities. An example of this can be seen in the state-federal rehabilitation system: historically, consumerism was informally, rather than intentionally, practiced within the counselor-consumer relationship. Counselors sought the input of their clients in order to assess needs as well as possible, establish rapport, and keep the client engaged. The 1973 Rehabilitation Act[23] included a provision for consumer involvement on state advisory councils and in the development of the Individualized Written Rehabilitation Plan.[24] Carney suggests that the passage of the 1990 Americans With Disabilities Act reflects the strengthening consumer movement.[24,25] These developments have been bolstered in the language on "informed choice" in the 1992 Amendments to the Rehabilitation Act of 1973.[26] The Final Regulations of the 1992 Amendments specify that each state rehabilitation agency should establish policies and procedures regarding informed choice:

> ***enabl[ing] each individual to make an informed choice with regard to the selection of long-term vocational goal, intermediate rehabilitation objectives, vocational rehabilitation services, including assessment services, and service providers. . . . This information must include . . . cost, accessibility, and duration of potential services, the consumer satisfaction with those services, . . . the qualifications of potential services providers, the types of services offered by those providers, and the degree to which services are provided in integrated settings.***[27]

The Twenty-First Institute on Rehabilitation Issues provides a list of 17 guidelines for the counselor's role in facilitating consumer choice in the rehabilitation process.[28] Among the 17 are these directives related to the use of community resources:

- Make the consumer aware of options.
- Share responsibility for identifying options.
- Make the consumer aware of implications of choices.
- Base informed choice on a pool of options.
- Advocate for consumer access to other programs and resources.

Implementing choice in community resources may take many forms. Minimally, a counselor or agency can keep a catalog of community vendors and discuss the pros and cons of each vendor with the consumer, who would then participate in choosing the vendor. Further steps may include developing the optimizing matrix (see earlier discussion) with the consumer and having the consumer both visit vendors personally and talk with other consumers about their experiences. Consumer "voucher" systems have been attempted in state rehabilitation agencies.[28] Under voucher systems, consumers are given vouchers with which to purchase services from the vendor(s) of their choice. Finally, developmentally appropriate training on how to be an "informed consumer"—with such topics as identifying and prioritizing one's own needs, gathering information on community resources, and decision making—can be developed and provided.

COMPUTERS AND INFORMATION TECHNOLOGY IN COMMUNITY RESOURCES:

The expanding use of computers and information technology in rehabilitation and human services since the 1980s has been documented,[29,30] with uses ranging from computer-assisted instruction and computerized testing and reporting to career exploration and case management. Computers and information technology are similarly found in community resources: referral letters and forms, payment authorizations, and follow-ups are routinely done on computer, often by counselors themselves. Peer self-help groups "reside" in networked conferences and e-mail discussions.[31] The Job Accommodation Network[32] provides online assistance in identifying and selecting adaptive devices to enable persons with disabilities to secure and maintain employment. Information and referral services are available from online networks.[33]

With the booming use of computers in case management has come concerns about the confidentiality and privacy of online records.[33] Federico and Bowley[33] note that, despite controls and gateposts, "hackers" have been able to access online information. **Counselors, administrators, and vendors using computers to promote the network of community resources should take the following precautions:**

- If referrals are to be made online or sent by e-mail, secure servers and encryption/privacy software should be used as a matter of routine.

- Because of e-mail's immediacy and informality, e-mail requests by vendors for information should be scrutinized to make sure that there is a current, signed release for the particular information being requested.

- Consumer case information stored at either agency or vendor sites should be protected by "firewalls" and other devices designed to keep client information inaccessible from the outside.

NETWORKED OR CONSOLIDATED COMMUNITY RESOURCES:

Efforts to consolidate community resources, especially in government but also in the private sector, are likely to change the way those community resources are accessed, as well as intake, assessment, and referral processes. In rehabilitation, these efforts are seen in the attempts to consolidate state agencies with other human services, most notably Job Services and mental health. **Various advantages of networked or consolidated services have been cited, including (*a*) single points-of-access for limited services, (*b*) decreased wait times between referral and acceptance, (*c*) elimination of service gaps, (*d*) raised consciousness about specialty-area-wide needs, (*e*) assistance for weaker programs, (*f*) maximization of coordination among services and cost-effectiveness, (*g*) maximization of professional relationships, and (*h*) comprehensive data/evaluation systems.**[21,35]

Raiff and Shore[21] examined documents on voluntary case management networks or consolidations that made recommendations about increasing the probability of success of these programs. Among the recommended characteristics or strategies are these:

- *Early involvement of respected individuals.* Early in the planning stages, persons from each prospective member organization whose counsel is respected must become involved.

- *Unequivocal administrative commitment for program start-up.* This should include not only philosophical commitment and support but also practical support through investing resources in the consolidation efforts.

- *Shared priorities and sustained high agreement about goals.* All parties should commit substantial effort to front-end planning, with planned on-site visits and need assessments.

- *Formal intersystem agreements and procedures.* Formal policies should be created for equitable distribution of service referrals.

- *A variety of communication channels.* Initially, there should be a great deal of face-to-face dialogue; this may evolve into group problem-solving meetings, group written reports, and shared staff meetings. Relationships are thus consciously developed and encouraged to grow.

- *Universal assessment instruments.* All members must use similar instruments for determining eligibility, program placement, and level of service. Shared networked instrumentation or computerized information systems are also recommended.

SYSTEMS CONSTRAINTS:

Counselors wishing to help their consumers as fully as possible and organizations trying to maximize their impact cannot develop a strong system of community resources if those resources do not exist.[36] There may be geographic constraints on the development of community resources when (*a*) there is a shortage of services in the community; (*b*) the community does not have the willingness or capacity to create services; or (*c*) the community lacks an adequate transportation system making the existing services inaccessible to consumers. There may also be constraints within the services themselves: Some vendors lack motivation to serve rehabilitation consumers, particularly those consumers who receive public assistance;[36] other vendors may be willing to serve persons with severe disabilities but lack the expertise. **These constraints not only hamper the efforts of the counselor or organization in optimizing the system,**

but also restrict the implementation of consumer choice in the rehabilitation process.

It will take coordinated effort to remove or overcome these constraints. Efforts should be centered around three activities: expanding community services, advocacy, and education. First, alternate strategies for expanding services will need to be considered, especially in rural or other areas that cannot support their own service network. Counselors and agencies should be more willing to look beyond geographic boundaries when seeking resources. New or expanding technologies, such as those associated with computers and the Internet, will provide access to distant vendors and may lead to the broadening of the meaning of community resource, as previously noted. For consumers needing job training, long-distance medical consultation, and consolidated service networks, video and computer conferencing may make distance learning more practical, successful, and affordable. **Counselors will have to keep up with the technology, and employing organizations will have to provide the technological infrastructure, ongoing support, and commitment, offering adaptive computing[31] to counselors with disabilities when necessary. Consumers exercising their choice will need access to the same technologies and will also benefit from adaptive computing.**

Second, counselors will need to expand their roles as advocates for their consumers. Advocacy should be directed toward those vendors who are unmotivated to serve specific consumers. **Counselors and vendors should engage in joint problem-solving to identify and remedy problems in the referral process. Counselors and agencies also need to advocate on the community level, to convince city councils and community decision makers to put more resources into needed services.** In these times of fewer public dollars being spent on services, greater vigilance will have to be exerted in monitoring service utilization, efficiency, and effectiveness.

Finally, education and training efforts should be multiplied. Rehabilitation counselors, rehabilitation educators, consumers, and consumer advocates—those with the most knowledge and skills in working with persons with disabilities—should use their expertise to provide training to vendors. **Training partnerships with vendors will not only increase the range of resources available to specific consumers; it may also make the community resource system more viable, as vendors and potential vendors become allies in efforts to improve services to persons with disabilities.**

Conclusion

Rehabilitation counselors are best able to serve consumers when they are aware of available community resources and utilize them effectively and efficiently. The important factor in utilizing resources is recognizing that community is situation-specific; each consumer has individual needs. The value of the community resources utilized are dependent on the nature of the consumer's needs and on how well developed the resources are. **Counselors should examine their practice to determine if they have placed any artificial geographic or other restrictions on their definitions of community.**

The systematic development and use of community resources consists of these five steps: needs assessment, potential resource identification, resource selection, referral, and monitoring. This is the most effective system in the long-term for meeting consumer, professional, and organizational needs. If conducted routinely, this system allows for the elimination of burdensome or redundant steps.

Like other activities undertaken by rehabilitation counselors or case managers, utilizing community resources will continue to be subject to larger technological, social, and political changes. It is advisable to keep up with those changes and to adapt professional practices accordingly. **Of primary importance in this area is the advent of on-line resources. The physical constraints of community are greatly lifted by these resources. Counselors must be aware of new ways to access resources to best serve consumers.**

Overcoming or eliminating the constraints on a resource system is essential to making the system effective and for enhancing consumer choice. Coordinated efforts in education, advocacy, and expanding the definition of community resources will be required to remove those constraints.

Appendix A

EVALUATION AND TRAINING CENTER REFERRAL

Please attach a signed, current release of information

ETC Case Number 1997-432-H

Referral Date 03/24/97

Client's Name	Social Security Number	DVR Case Number
[illegible]		

Street Address	City	County	State	Phone #

Birth Date	Age	Marital Status	Primary Disability	Secondary Disability
			Spinal Cord Injury	Blindness in one eye

Referring Agency	Referring Counselor	Address	Phone #

Services available at ETC (Check all services required)

X Psychological Testing	____ Independent Living Services
X Vocational Evaluation	____ Adult Basic Education
X Computer Skills Evaluation	____ Supervised Residence
____ Placement	____ Transportation

Reason for Referral (Include specific questions you wish answered for Vocational Evaluation, Independent Living Services, etc.)

This client has requested assistance with attending college to get his Bachelor's degree in Computer Science. All of the client's previous jobs required walking and more physical stamina and strength than he has or is likely to develop. He also has no functional use of his left arm. He can no longer return to employment of the same nature as he formerly held. Please test him to determine if he has the aptitude for computer science, and a reasonable chance of succeeding in college if appropriate academic support is provided. Will he require any reasonable accommodations (e.g., readers, modified testing) to succeed in college? What specialties in computer science would be best suited for him? Will he benefit from adaptive computing devices?

Reason for referral for psychological testing (Please include specific questions you wish answered.)

The client received a "general discharge under other than honorable conditions" from the US Marines in 1987 for refusal to follow orders. He has also been unwilling to cooperate with me a couple of times. Does this pattern reflect a general trait that will affect his ability to complete his degree, and subsequently obtain and maintain employment?

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

13. Which of the following statements is/are correct?

I. In identifying potential resources, informal sources may include references from other professionals both within and outside one's own agency.

II. In selecting resources, "satisficing" represents a compromise between the consideration of every conceivable alternative and the time and information constraints of such a strategy.

III. In using community resources, counselors are advised to avoid computers for referrals as there is no way to ensure consumers' privacy.

A. I and II

B. I, II, and III

C. I only

D. II only

14. According to Crimando and Riggar, which of the following is not a Health and Diagnostic Services resource in the rehabilitation process:

A. Home Health Services

B. Pain Clinics

C. Family Planning

D. Alcohol Drug Programs

15. Which of the following statements in *not* correct?

A. Needs assessment is the collection, analysis, and synthesis of data regarding the needs of a person or organizational entity.

B. The steps in systematically identifying, selecting, and using community resources are needs assessment, potential resource identification, resource selection, referral, and monitoring.

C. Needs are usually defined in terms of discrepancies between current levels of functioning and ideal levels.

D. Counselor and organizational needs are not as important to identify as consumer needs are.

16. In monitoring community resources, which of the following is *not* something to which a counselor needs to pay close attention?

A. Gathering the appropriate data for program evaluation

B. Measuring the responsiveness to the needs outlined in the referral letter

C. Creating a list of ancillary services needed by the consumer

D. Assessing a consumers' satisfactory progress, or offering an explanation if it is unsatisfactory

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Directions in Rehabilitation Counseling

Volume 9 Lesson 5

Counseling Strategies With Native American Clients

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Wah-doh, my friends.

Introduction

Native Americans are not a single homogenous group. Each of more than 500 Native American cultures are unique and differ from other native cultures in language, culture, belief system, life style, dwelling, food, clothing, and other areas of life. There are some aspects, however, that can be generalized among Native populations, and which frequently create barriers between Native American vocational rehabilitation clients and their counselors. To combat these barriers, this lesson will: (1) identify and define terms related to Native populations; (2) identify critical issues and briefly discuss them; (3) offer suggestions on protocol and behaviors that help create a stress free counselor/client relationship; (4) present case studies to illustrate the issues; and (5) identify successful strategies through the use of the case studies.

Defining Terms

American Indian/Native American: These are terms for the original inhabitants of the Americas. Each Nation has a name for itself that may or may not be the common English term for them (Diné is the name Navajos call themselves). Most native people prefer to be called by their original tribal name, but will accept either American Indian or Native American as a general classification. However, in an informal poll taken at a pow-wow in 1992, the younger people (ages 35 and under) preferred the term Native American. Ask your clients which they prefer. In this lesson, Native American will be used.

Indigenous People/Aboriginal People: Since the worldwide inclusion of native people in many political and social movements, the term Indigenous People has become popular to identify the original inhabitants of an area. The term

Aboriginal People is often used in Canada for its First Nations citizens. Both of these terms refer to the original inhabitants of an area.

Tribe/Nation: Many official names of tribes have become "Nation," such as the Navajo Nation and the Cherokee Nation of Oklahoma. Some groups retain the term tribe, such as the White Mountain Apache Tribe. In this lesson, every attempt has been made to use the proper term when referring to a given group.

Indian Health Service (IHS): The main service provider of health care for American Indians is the IHS. Small clinics and hospitals are maintained on reservations, and larger regional hospitals are located in various off-reservation cities. The IHS Headquarters, a branch of the Public Health Services, is located in Rockville, Maryland.

Bureau of Indian Affairs (BIA): The BIA originated in the Department of War and now is located in the Bureau of the Interior. The BIA oversees all tribe/nation programs funded by the U.S. Government. It has trust responsibility for tribal lands, holds investments for Indian Nations, and is responsible for educational services on reservations. BIA police are employed in tribal law and order, and BIA social services provide various programs for tribal people.

Tribal Governments: Each tribe/nation is required to establish a government of its own, patterned after the United States Government. There are Tribal Chairpersons and a body of council people, as well as individuals who administer tribal programs. It is important to note that tribal governments function as entities separate from the BIA or IHS, although there may be some overlap of programs (e.g., both after social services).

Important Factors for Rehabilitation Counseling with Native Americans

In a ten-year study,[1] Native Americans cited the lack of cultural understanding as the single most important factor that created barriers for them in interacting with service providers. This refers to the lack of background into 500 years of history, spiritual issues, and languages of Native American peoples.

A good source of information for rehabilitation counselors is the Wounded Eagles Network.[2] The Wounded Eagles comprise a national network of Native Americans with disabilities, their families, care providers, and friends. The network members have exchanged information, personal responses, and advice and provide this information as a resource for service agencies and institutional administrators. Although the majority of their input relates to service needs, a significant portion deals with cultural issues related to rehabilitation service provision. This lesson focuses on the issues related to the concerns of the individuals who provided the information: tribal people who have experienced that about which they speak.

Cultural Understanding: Critical Issues for Native Americans

Lack of understanding of diverse Native American cultures contributes to difficulties throughout the rehabilitation process by both counselors and Native American clients.[3] Understanding a culture includes knowledge of its people and their ways of doing things; their thinking, reasoning, and behaviors; and the basis of their attitudes and beliefs. The following information will provide knowledge to which non-Native Americans often have no access, clarify nebulous images created from fragmented information, and assist counselors in working successfully with Native American clients.

HISTORICAL EVENTS AND INDIGENOUS CULTURES:

"Native Americans" is a loose category that includes over 500 tribes, as many cultures, and 300 languages. Pre-Columbian inhabitants of this land may have numbered as many as 15 to 30 million.[4,5] The population was decimated by disease, starvation, dehydration, and exposure to the elements even more than by war. By 1890, they numbered less than 250,000.[6] The original cultures, traditions, and spiritual practices of the groups may have changed over time but the core cultural beliefs and practices remain.

CULTURAL AND SPIRITUAL STRENGTH:

Strengths of Native American cultures are based on traditional values and spirituality. An amazing strength is found in "Stand Proud," an educational program based

on the cultural values of urban and reservation families. **The most prominent values are: respect for and from family, clan, and tribal members; providing for the family, clan, and tribe; honoring ancestors by retaining the Old Way; not seeking to rise above others; and walking in harmony with yourself, your family, clan, tribe, Mother Earth, the universe, and the Creator.**

Spiritual strength is found when one maintains contact with the Creator at all times, prays often, observes old rituals, takes care of sacred objects, guides his or her life by the teachings of the Elders, asks direction and council from the Creator, and walks in harmony to prevent unwellness in body, mind, or spirit. **The Old Way teaches that all the two-legged creatures (humans) are brothers and sisters, and all creations are relatives, including those on, in, around, and above the earth. Nothing happens by accident; all things have a reason and a cause. Reasons are often spiritual, though causes are often both spiritual and physical. People must learn the lessons they came to this life to learn, teach what they came to teach, and live so that they can return to the Creator without shame.**

Many tribal people have embraced organized religions today. Some may choose a religion to the exclusion of the Old Way, and others may blend the two. Still others may not have had the opportunity to learn the Old Way.

BASIC FACTS OF NATIVE AMERICAN LIFE:

There are basic facts of Native American life that every counselor should know. A lack of cultural knowledge has taken a great toll in terms of human potential and financial costs, and acquiring such knowledge is expeditious and wise. The following are some facts that have the greatest impact on rehabilitation services.

Tribal Governments

Tribal groups commonly have a government modeled after the American Federal system in addition to a strong traditional leadership system.[8] The latter is composed of a governing council and spiritual leaders, and includes women. The imposed style of formal government has created a certain amount of disarray in these communities because of tribal unfamiliarity with non-tribal forms of governing.[9]

Cultural Retention and Maintenance

Most tribes today retain some of their traditional culture, from remnants of the culture to nearly all of it. Crafts such as pottery and basketry are being passed on, as are the arts of woodcarving, boatmaking, and home- and sheltermaking. Weapons such as lances, bows and arrows, and spears are still made. Other items such as baby carriers, cradles, flutes, other musical instruments, toys, and game items are still created but may have limited use in today's world. Ceremony and ritual items remain important parts of the spiritual and religious lives of tribal people.

Lifestyle Changes

The original lifestyle of tribal members is not possible in most areas. Even in the far reaches of large reservations, modernizations such as pick-up trucks and gas-powered hand tools are used. **However, tribal people cling to their cultural and spiritual values, often integrating the new with the old and using the new to preserve the old.** Many Native American families attend pow-wows as well as sports events, may see a medicine person as well as a physician, and may carry on their traditional spiritual rituals as well as go to church. Children are taught both the old and new ways, and in most homes every attempt is made to retain the tribal language. Some changes have been destructive, but adaptation to new ways has also created strengths and cross-cultural application of modern products that are truly ingenious. A recent pow-wow demonstrates successful adaptation: in the center of the back bustle of a fancy dancer was a beautiful circular object with rainbow iridescence—a compact disc! The dancer's variation on beadwork was a creative use for an object from another culture.

Education

Since the advent of public schooling on Native American lands, boarding schools are being closed.[10] Reservation public school curriculum contents are usually similar to those in any school, often with the addition of cultural and language classes and a bilingual approach to basic subjects. However, many students do not graduate

from high school and even fewer go to college. National organizations such as the National Indian Education Association promotes educational success, higher education, and appropriate education and/or inservice training for teachers unfamiliar with bilingual/bicultural education and Native American cultures. Although great strides in literacy have been made, much remains to be done.

Humor

The stoic Indian face of Hollywood stereotype has never revealed a side of Native American life that is critical to survival: the ability to create humor. Laughing at oneself is a talent; the greatest and most gifted directors at pow-wows are those with the wildest sense of humor. Humor is used to relieve stress, break tension, and create a positive atmosphere during meetings or sessions. It enables an individual to survive some of the hurtful events of life. Humor, however, may not be shared with outsiders unless the person feels comfortable in doing so.

500 Years of History—Its Impact on Native American Lives

There are certain historical and not so historical events that counselors should know about Native American history. These events are: (*a*) The Dawes General Allotment Act of 1887 took 87 million acres of Native American-held land away from tribes, shattering homes and leaving 100,000 people landless.[11] (*b*) Congress granted citizenship to the majority of Native people in 1924, but without the right to vote.[12] (*c*) The Indian Reorganization Act of 1934 (the "New Day") had good intentions[13] but was severely blundered by Congress. It forced tribes to accept European-American standards and systems as a requisite to receiving the benefits of the IRA.[14] (*d*) In 1942 an estimated 900,000 acres in Alaska and 16 Indian reservations in the West were taken to be used as military installations, with little or no payment to those who had to move.[15] (*e*) In 1948 Arizona Indians were granted the right to vote,[16] which New Mexico Indians did not get until 1962.[17] (*f*) A Termination and Urbanization policy was implemented in 1953. The government attempted to terminate the tribal identification of 109 tribes, taking their land and leaving them impoverished and homeless.[18] (*g*) The urbanization policy was called Relocation, and in 1952 the government began removing families from reservations and placing them in city centers, giving the men job training, and expecting the family to assimilate.[19] (*h*) Boarding Schools provided minimal education with maximum discipline, separated children from their families from age 5 to 18, and created generations of barely literate individuals who were ignorant of their tribal customs and language.[20,21] (*i*) As adults, boarding school children often repeated in their own families the punitive and harsh discipline they experienced; this is now called child abuse.[22] (*j*) A government program in the early 1960's took children away from their families for adoption into non-Native American homes, resulting in a rate of removal 19 times greater than that of any other group of children.[23] The program was so devastating to families and children[24] that it took a Congressional Act (Indian Child Welfare Act of 1978) to stop the atrocity.[25] (*k*) The atrocities caused by the Indian Reorganization Act were not officially ended until the passage of the Indian Civil Rights Act of 1968 and the Indian Self-Determination and Educational Assistance Act of 1975.[26,27] It was not until these two acts that the right of both citizenship and voting in national elections were solidified. (*l*) The Alaskan Claims Act of 1971 returned 44 million acres of land to native control, but put 462.5 million acres into for-profit corporation control.[28,29] (*m*) Religious freedom was not extended to native people until 1978,[30,31] and then only partially so.[32] (*n*) The legal definition of being Native American is often difficult to determine due to past government decision, tribal roll criteria, and the lack of documentation of Indian heritage by many Native people.[33] (*o*) In the 1990's new threats have arisen that make the local and national newspapers and TV news broadcasts. The National Congress of American Indians, the oldest and largest Native American organization in the United States,[34] attempts to keep abreast of federal, state, and local challenges and to counter them when possible.

These are but a few of the events that have impacted Native American life. Each individual tribe could add specific items to this list. Native American people live with the memory of these events every day, while new assaults continue to occur. And yet, Native Americans still

exist, still embrace traditional cultures, and refuse to vanish into the melting pot of America. Tribal/Nation pride and honor for spiritual values remain strong; unity for the survival of all native people has made them stronger.

Postcolonization Stress Disorder—All Native Americans Are at Risk

Native Americans carry with them the anger, grief, and hopelessness created by being members of conquered nations. Emotional and psychological trauma is intergenerational, and there is no escape from this history. This pain and grief is present still today as a part of family and personal experiences and memory. **This condition may be termed Postcolonization stress disorder** (PCSD).

Chances are that the Native American individual who comes to see a rehabilitation counselor will have some degree of PCSD in addition to another disability. The counselor should remember that 500 years of history has left the offspring of colonization survivors with rules of behavior and bits of knowledge that enable them to survive. Most tribal people can remember whispered words similar to these:

> **Don't ask them for anything; you won't get it anyway. Always agree with them. Humble yourself to them, they like it. Don't cross them, ever, or you or someone in your family will pay. Never speak up to defend yourself. Never call attention to yourself. Do these things and they might let you live in peace. At least you will live.**[5]

The "them" and "they" referred to above are members of the dominant society, especially ones that wear uniforms or have authority of any kind, including a rehabilitation counselor. "They" are often viewed with fear and mistrust. This may sound unthinkable in the 1990's, but survival skills tend to live on and on even when their need has long past. And for tribal people, the need often still seems to be present, thus they tend to react according to the rules they were taught.

It may have taken weeks for the Native American client in a rehabilitation office to gain the courage to call for an appointment, and longer for him or her to actually walk in. And he or she most likely will be expecting to be denied services.

Remember that these are learned behaviors, responses that can be modified by positive encounters with "them." Remember too that today's counselors are not responsible for the 500 years of history, but they do have the opportunity to erase some of the hurtful results. Above all, remember that a counselor is a service provider and the Native American is a client. As professionals, counselors want to do their very best to meet a client's needs, including the need to have pleasant, stress-free, appropriate counseling sessions and the need to be treated with respect and dignity. **The aim is to foster trust between counselor and client; this will greatly enhance both the relationship and the employment outcome.**

Clients with a traumatic stress disorder, regardless of the cause, are likely to have a personal history of substance abuse, violence, petty crimes, poor school and employment records, and difficulty in interpersonal relationships. A good reference for general stress disorders is Daniel Goleman's *Emotional Intelligence*, particularly Chapter 13, "Trauma and Emotional Relearning;"[6] a study of PCSD in particular is Eduardo and Bonnie Duran's *Native American Postcolonial Psychology*.[7]

Native Americans experience their cultures and traditions ranging from a minimum or no exposure to tribal culture to total life experiences in their culture. Events that impact on the acculturation of a Native American into mainstream American society include education levels and experiences, time spent away from the reservation or tribal community, contact with organized religions, and degree of Native American blood. Individuals who have firm roots in their traditional cultures are often the ones who are more able to walk successfully in two worlds. The person who has had little or no ties to his or her tribal culture and yet has not been fully assimilated into the dominant society may have great difficulty in defining an identity and belief system for him- or herself. The stress of living in and dealing with two worlds while not being competent in either may impact greatly on a Native American's ability to overcome symptoms of PCSD.

Counseling the Native American client with PCSD requires a relaxed, nonthreatening atmosphere

and an emphasis on the possibilities and types of assistance a counselor may have to offer. Since stress disorders have few observable characteristics and may be undetectable, a personal history from the client is the best indicator that a stress disorder exists. This client will probably need psychological help, perhaps from a traditional medicine person. He or she will also need training for an employment position that would aid in modifying PCSD-induced responses.

Acceptance and Stereotyping—Who Is Really What and Why

Acceptance is a two-way street; counselor and client must accept each other and agree to work together. **To offer acceptance one must set aside stereotypes, preconceived notions, and common misconceptions which generate anger. Rigid religious or social tenets tend to wound the heart, and preconceived notions and Hollywood-inspired concepts indicate prejudice and a lack of knowledge.** On the other hand, Native people also stereotype non-Natives using "types" that derive from history, religious and social behaviors, and "moccasin telegraph" (grapevine) stories. This also indicates prejudice and lack of knowledge. **The way to create acceptance and erase stereotyping is to learn about other cultures. Misinformation and misconceptions can be changed and a sound basis for acceptance can be established.**

Physical appearances are often stereotyped, but skin tones, hair texture, facial features, stature, etc., vary from tribe to tribe. The Hollywood version of what a Native American looks like is roughly that of the Plains Indian, although the most well know face is that of Iron Eyes Cody, a Cherokee.[18] Also, many Native Americans have intermarried, and their children may have physical characteristics of other groups. Nonetheless, their cultural roots and language may be that of a Native people. **Some things not to say to a client include: "You don't look like an Indian;" "Some of my best friends are Indians;" and "My great-great grandmother was an Indian princess." These statements are viewed as insulting and patronizing and they reveal a total ignorance of Native cultures.** Instead, comment on arts or crafts you admire, the last pow-wow you attended, or speak about other real, tangible subjects. If you have a Native American friend, talk about it another time, giving a name and a tribe. If you have a Native heritage, also speak of it another time and include a specific tribe, specific location, and specific agency of enrollment or possible enrollment.

There are several degrading stereotypes of Native Americans which tend to perpetuate themselves in the larger society. The worst is the "drunken Indian" image; this is a social stigma that is unjust and hurtful. Then there's the "noble savage" image and the word "squaw." Both of these terms are as out-dated as the image they project. Also, the term "squaw" is sexually degrading and highly insulting to native women as it is a slang term for vagina. Stereotyping of non-Native Americans is usually that they "speak with forked tongue" (i.e., don't tell the truth), have a "better than thou" attitude (i.e., prejudiced), talk the "Jesus way" (i.e., religious fanatic), or simply that they are "typical whites" (i.e., a mixture of all the above with the addition of a loud voice, always talking, and rude). It is as difficult for Native Americans to set aside these stereotypes as it is for non-Native Americans to set aside theirs. Only by agreeing to accept each other at face value and working hard together to topple the stereotypes can both individuals grow in personal strength and understanding.

Misconceptions That Wound the Heart

What do spirituality and religion have to do with rehabilitation counseling? Wounded Eagles have said that the misunderstanding of tribal spiritual beliefs have created great stress for them during interaction with non-Native Americans because of the moral and character judgments attached to the misunderstandings of their beliefs. For example, Native people have been considered to be heathens and infidels and their rituals and ceremonies pagan.[19] No counselor would enter a session knowingly carrying preconceived judgments, but the fundamental beliefs that foster such unjust labels may be part of their cultural and religious lifestyle, and part of their unconscious mind. For a counselor to recognize the possibility that he or she may harbor such judgments is a step toward erasing them.

Dominant religions in the United States originated on other continents; Native religions are indigenous to this continent. Most dominant religions are based on written texts, require a certain place dedicated to worship, require a specific day of the week to be set aside for worship, have memberships, and have rituals and ceremonies by which to confirm and perpetuate that religion. Religions of indigenous people generally have no written texts, specific place or time for worship, or membership rolls. But they do have rituals and ceremonies.

Generally, most dominant religions teach that there is a Creator which is supreme over all other Creators. Most Native people believe there is a Supreme Creator, and that no matter what form or ritual an individual uses to access that Entity, it is still the same Supreme Creator. Before European contact, tribal languages had no words for sin, hell, salvation, baptize, or other words specific to text-based religions. To this author's knowledge, tribal warfare on this continent based on religion did not occur.

Looking from the other side of the picture, European settlers had never encountered spirituality without formalized religion nor an individual-based spirituality that functioned through each person's direct contact with the Supreme Creator. Europeans had no cultural category for the Native American spiritual leader, who often was a combination of leader, teacher, counselor, and healer as well as the one who was the recipient of orally-transmitted tribal history and formulae for spiritual ritual and ceremony. The people who came to this continent had had little or no previous contact with the cultural traits here and therefore had no basis to categorize them except by their own religious tenets. Prejudices and erroneous judgments were bound to occur.

People are often unaware that much of what they do and say, how they respond, and their judgment of other people are based on their own tradition and religion. A religious teaching often becomes a religious doctrine, which becomes a cultural moral, which becomes a measure by which to judge others, or a stick with which to beat them for infractions.[9] Consider the work ethic; probably based on the biblical passage "by the sweat of your brow...," it quickly became a moral judgment, then a character judgment, then a social standard which regiments our lives even today. Counselors who are well-grounded in their own belief system have an inner security that allows them the freedom to understand and respect other cultural and religious belief systems. **No one need give up his or her own beliefs to be sensitive, but being aware of how one's personal religious teaching may overflow into the counseling office and color thoughts, concepts, and responses is a valuable asset to the counseling professional.**

Languages—Communication With Tribal Clients

While there are over 500 distinct tribes/nations in existence today, there are only about 300 different tribal/nation languages still in use.[10] **There are several factors that need to be addressed concerning people who come from backgrounds where tribal languages are spoken: the language, language within its culture, word meanings, and English as a second language.**

Many of the sounds in Native American languages do not occur in English and English sounds often do not occur in Native languages. There are no tribal translations for certain English words, and a Native American client may or may not attach the same meaning to English words as the counselor does. **The client may have difficulty following a conversation if the counselor speaks rapidly, and may not have a complete or accurate definition of terms used. Counselors may use rehabilitation jargon, forgetting that other people may not understand it. A client may struggle to find the English words to express a thought, may express thoughts differently, or may even stop speaking out of frustration.**

Although the majority of Native Americans speak English, it may be their second language. In such cases the client often has to mentally translate from the tribal language to English and back again each time a verbal exchange occurs. This translation may slow verbal responses. Even if a client does not have a tribal first language, if he or she was raised in a home where a tribal language was spoken, there probably still will be multiple-language thought processes as he or she searches for the correct words in the correct language.

Every culture has protocols for verbal interaction, such as not interrupting. **In most Native cultures, pro-**

tocol calls for a 5–6 second lapse between one person speaking and another replying. The dominant culture commonly has a lapse time of 2–3 seconds before the initial speaker will either repeat what was just said or continue with another sentence. Verbal protocol of Native American cultures, coupled with a translation or multiple-language thought process, may increase the lapse time between being spoken to and responding to as long as 7–8 seconds. Such a lapse is common in Native American cultures, but is not common in the communication patterns of the dominant culture. **Counselors might become frustrated at the failure to get the client to respond, view the non-response as hostility or a lack of cooperation, and terminate a session. However, the counselor may say "Now let me hear what you think," and sit quietly for as long as it takes for the client to form English sentences to express internal feelings.**

Effective Counseling: Tips for Counseling Native American Clients

The following statements are a collection of protocols that most Nations follow, although individual tribes may add specific items to the list. **The protocol are considered good manners and will do two things for a counselor: (*a*) make the session with a client go much more smoothly, and (*b*) let the client know that the counselor has taken the time to be informed about Native cultures.**

Eye contact is commonly considered rude if it is constant. Eye contact should be fleeting and brief; this denotes respect for the other person. Staring straight into another's eyes is hostile and disrespectful.

Reason: The eyes are pathways to the spirit; to stare is to endanger the spirit of the other person.

Handclasp takes the place of a handshake in most tribes. The clasp is gentle, little more than a touching of palms, and there is no shake. Using the handclasp will tell the client that you are aware of traditional manners; the client may opt to offer a handshake because that, to him, would be appropriate to the counselor. The counselor would not go wrong with the clasp; and remember that handclasps are acceptable at the close of the interaction as well as at the beginning.

Reason: A hard, vigorous handshake is an aggressive show of power and superiority of one individual over the other.

Quiet time is important in establishing a good relationship with a Native American client. When a Native American comes into your office, give a greeting and then ask the client to sit down. Allow about a minute of nonverbal, non-interactive time. Shuffle papers. Rearrange books. Search for some obscure object. Then get your materials, go to a chair near the client with no desk between you, smile, and remark about the weather, a football game, etc.

Reason: Tribal protocol of silence for a time at the first few meetings allows for the essence or spirit of one person to sense the spiritual essence of another and to adjust to it. Warm, friendly essences put others at ease; tense essences bring up barriers.

Unwritten laws include, but are not limited to, those of hospitality: Always offer someone who comes to your door (e.g., office, clinic) refreshment, if only water. A cup of coffee would be better, or perhaps a counselor could keep a small dish of hard candy on hand. Keep artificially sweetened snacks for diabetics, a disease common among Native Americans.

Reason: Visitors to one's home usually had to travel some distance to get there. At the end of the travel they were in need of refreshment, often greatly so. To refuse to provide water, a safe place to rest, and food, if needed, was shameful.

Introductions. In many tribes it is rude to ask a person's name as the first question. Usually what is asked is, "Where are you from?" Talk about that for a few minutes, then say "Oh, I forgot to introduce myself. My name is...." The client will usually respond with his or her name.

Reason: Names are considered personal property in many Nations. Also, tribal people might have a tribal given name and a government issue given name. A name may not be shared until the person has determined which name is proper to use.

Never make a promise unless you are sure you can keep it. The counselor should not say he or she can do something unless absolutely certain it can be done. Keeping a promise builds trust and respect.

Reason: Giving your word is almost sacred. Indigenous Nations have signed hundreds of treaties, the ma-

jority of which were broken by the Government. The client may not fully trust you in the first place, and if for some reason you can't do what you promised, trust and respect are diminished.

Offer suggestions, not directions; encourage, don't push; let the client make the final decision without pressure. Respect the client's decisions and support the decisions as best you can.

Reason: Native Americans have had decisions made for them and about them for centuries, but few decisions were made with them or by them. Allowing a client to control his or her own rehabilitation program conveys respect for personal decisions.

Commitment. The counselor will most likely need to have more interaction with the Native American client and his or her family than would normally be expected.

Reason: A rehabilitation counselor's position in a tribal context is one of helper, a sort of healer and "wise talker." When a counselor is placed in that community category, he or she becomes part of the cultural network, which includes invitations to feasts, ceremonies, weddings, and other functions. If a counselor cannot attend, proper protocol would be to send a small gift (food items are always appropriate) and a note of thanks and apology.

Case Studies—Counselors and Native American Clients

The following three case studies are presented to illustrate effective rehabilitation counseling with Native American clients. After each vignette, the strategies employed by the counselor will be highlighted.

CASE STUDY ONE:

Fred, a male counselor, was not prepared for the appearance of John, self-referred to vocational rehabilitation services. John was a Native American male, over six feet tall, with braids that reached nearly to his waist. He wore a western hat and boots and stood silent at the counselor's door.

Fred had made himself somewhat familiar with Native American people. He had gone to several pow-wows and got to know some of the dancers and art exhibitors. He had used those times to observe interactions and learn about the cultures. He got up from his desk and came around to greet John with a handclasp, then bid him sit down and be comfortable. John sat; Fred, shuffling papers around, studied John unobtrusively and observed how he sat, his posture, his composure, and the way his eyes moved over every object in the office. Then Fred offered John coffee, which he took, commented on John's hat that now lay in his lap, and settled into a chair near John. The two talked about the hat for a few minutes, then Fred introduced himself. John responded with his own name. Fred asked where he was from, and John said Florida. Fred asked what Nation, and John said Creek and Choctaw. Fred said he was not familiar with those Nations, and John spent a few minutes giving him a brief introduction.

Fred could see that John sat in an unnaturally stiff manner, so he asked "do you have pain?" John nodded his head but said nothing. Fred asked how he could be of help. John made several attempts before he started talking. He said he was a Vietnam veteran, that he had lost part of a hip to mortar rounds, and that he could not go back to his first job, truck driving. He hesitated; Fred sat quietly. John tried again; stopped again. Fred waited. Then John said that he had been to another counselor the year before but didn't get any help. Fred asked why. John said that the counselor had told him to go home and cut his hair and then come back. John never went back. Fred waited again, then asked why the counselor had said that. John replied that he was told no one would employ him as long as he had braids. Fred could see that John was tense, that there was more to the story. He said, "Tell me about your braids." John had made a promise to the elders and the Creator that, if he returned from the war, he would not cut his hair. They were a symbol of the Old Ways, the Old Warriors who had gone on, and of his cultures. Then Fred told John he appreciated his sacrifice for his country, that he honored and respected his promise to the elders and the Creator, and that he would do everything in his power to help him find employment and to lessen his pain. He referred John to the veteran's hospital, then arranged for him to study counseling techniques. John now works as a liaison between local tribes and state agencies and related

organizations. He has built a solid reputation for himself as a peacemaker. And he still has his braids.

Counselor's Strategies

(*a*) Fred had learned something of Native American cultures; (*b*) he observed proper protocol; (*c*) he created a common ground between the client and himself—the hat; (*d*) he observed appropriate silences; (*e*) he was nonjudgmental; (*f*) he showed respect; (*g*) he made no promises, but rather he said he would do his best to help.

CASE STUDY TWO:

Kathy had made and failed to keep three appointments with the vocational rehabilitation counselor, Anne, but kept the fourth appointment. Anne, who had gotten the referral from a local Native American Center, was surprised to have brown-haired, green-eyed Kathy walk in. Her dusky complexion indicated native heritage, and her poise was almost defiant. Anne had been involved in Native community activities. She had learned that "mixed bloods" like Kathy often did not fit the stereotypical image of a Native American but were fiercely proud of their heritage. Anne invited Kathy into her office, offered her a chair, and moved papers and folders around on her desk for a few moments. She also observed Kathy, whose face was sullen and frightened. The client's eyes roamed the room but several times flicked back to the bowl of candy on Kathy's desk.

Before Anne began informal talk she picked up the bowl, took a piece of candy, then offered the bowl to Kathy, commenting on a mid-afternoon lack of energy. Communication started around the candy, and soon Kathy was more at ease. Anne then introduced herself, as did Kathy. Anne said, "Tell me about yourself" and Kathy seemed to freeze. Anne quickly began to talk about herself, her family, and her house. Kathy began to relax. She asked Anne questions, and soon Kathy began to talk about herself. Kathy's grandparents had been part of the government's relocation project during the 1950's. The whole family had been removed from the Apache Reservation and transferred to Chicago to start a new life. Her grandparents died in the new environment and Kathy's mother, who had been a child during the relocation, was left alone as an eighteen-year-old in an environment which she did not understand and in which she did not function well. She started drinking and hanging out with the wrong crowd, became pregnant with Kathy, and continued to drink after Kathy's birth.

Kathy spent her life going from foster home to foster home. Anne detected anger in Kathy's words but mostly hurt and hopelessness. Kathy had come to vocational rehabilitation because someone at the Indian Center said they could help her. Because of her involvement with Native communities, Anne was aware that Kathy had symptoms of postcolonization stress disorder. Anne realized that Kathy needed to be treated as a whole person, that her emotional grief and psychological trauma had to be addressed as well as a physical disability resulting from a car accident. She might also need an evaluation for substance abuse. Anne first asked if Kathy knew of a medicine man who could help her rebalance and return to harmony. Kathy said she knew of one but that he lived in another area. Anne said she would try to make arrangements for a meeting between Kathy and the medicine man. Anne asked Kathy what she wanted out of the counseling. Kathy said that her arms and shoulders were okay after the accident but that she didn't have the physical strength to go back to her old job of elder care, which required upper body strength and mobility. She also said she needed help dealing with her emotions.

Anne made arrangements for Kathy to obtain grief counseling and traumatic stress counseling, evaluation and treatment for substance abuse, and with Kathy's consent, placed her in a telephone repair course. Kathy exitted the program a year later as a successful client. She visited her reservation and decided to stay, transferring her work to a nearby city.

Counselor Strategies

(*a*) Anne had familiarity with physical characteristics of tribal groups and "mixed blood" people; (*b*) she observed the body language of the client; (*c*) when barriers arose, Anne changed the subject to more comfortable topics; (*d*) her skills in interpersonal interaction put Kathy at ease so she felt comfortable to share her personal history; (*e*) she recognized symptoms of PCSD; (*f*) she formulated plans for holistic rehabilitation (body, mind, and spirit) while addressing alternative job skills; (*g*) she continued to follow Kathy's progress up to her return to her reservation.

CASE STUDY THREE:

Mike had been a vocational rehabilitation counselor for three years, was very good at his work, and wanted to help people obtain appropriate employment. He had studied multiculturalism, read books on different cultures, and prepared himself to serve his clients. He had limited personal contact with minorities, especially Native Americans, but felt somewhat qualified to work with that population. When Mary Black Owl came to him, he wanted to assist her, but realized that there were barriers to the counselor/client relationship. Mary was older than Mike. She talked to him, and answered his questions, but Mike had a difficult time understanding her. Most of the time she didn't communicate at all. Her handclasp had been very light and her long skirt and long sleeve blouse indicated she was more comfortable with traditional dress. She had not met his eyes a single time. Mike could not detect a disability and wondered if she even qualified for vocational rehabilitation services.

When Mary first came to his office, he offered her coffee. She requested water. He asked where she was from, she said "Window Rock." Mike knew that Window Rock was the community in Arizona where the Navajo Tribal Government was located. He asked her about her family; she lifted her shoulders and then let them drop. He asked how he might help her; she said, "I need a job." What kind of work was she looking for? Another lift of the shoulders. He asked about her family. She turned her head and pushed out her lips toward the north.

Mike felt he was not making enough progress with this client to ask about a disability. He was male, she was female. She was about his mother's age. Both facts were possible barriers to his communication with Mary. He felt she would be more comfortable with a female counselor who was her age or older. Mike said, "My Grandmother, I am very young, I do not have the wisdom of years to know how to help you. Please be comfortable while I ask someone to come in who does have the wisdom."

Mary sat a moment, then nodded. Mike then called a coworker, a female preparing to retire, who had a treasure of experiences with clients. Janice stepped into Mike's office, and Mike offered her his chair while he stepped back behind his desk. Janice smiled at Mary, then began talking about grandchildren. Before long Mary was telling Janice about her grandchildren, about her daughter and son-in-law who had asked her to come baby-sit in another city while they both worked. Both of them had lost their jobs, the family had to move to yet another city, so they gave Mary bus fare home. It wasn't enough; Mary got as far as Dayton, ran out of money, and ended up at the Salvation Army. Someone had sent her to the Vocational Rehabilitation Center for help in getting a job. She had no disability and didn't really want a job, but she needed money to get home. Janice took Mary to her own office, made several phone calls, found Mary temporary shelter and food, and arranged for her transportation home through a traveler's aid program. She then called the Navajo Nation Social Services for directions on how to get Mary from the closest bus depot near the reservation to her home. The tribe agreed to notify family or clan members to meet Mary in Gallup, New Mexico. Then Janice gave Mary a stamped, addressed card which Mary was to write on and mail to Janice once she reached home. A week later Janice shared the card with Mike; Mary had made it home fine, said thank you to Janice and to the nice young man who had given her water.

Counselor Strategies

(*a*) Mike recognized his limitation in dealing with Mary; (*b*) he recognized Mary's non-verbal communication patterns as those of a very traditional person; (*c*) he knew proper protocol concerning male/female interaction; (*d*) he knew the implications of age and the limitations it placed on him; (*e*) he used the term of honor and respect one shows for Native American elders (Grandmother, Grandfather); (*f*) he deferred to another counselor who would have no gender or age issues with the client; (*g*) he stayed behind his desk to observe and learn how Janice interacted with Mary; (*h*) Janice opened conversation so that Mary could say why she was there and what she needed; (*i*) Janice sensed that Mary was not really interested in working; (*j*) Janice did not turn Mary away as an unqualified candidate for services but instead helped her in the best way she could; (k) the card Janice gave Mary was a bridge between Mary's world and Janice's world, a bridge that gave Mary assurance on her long ride home.

SUMMARY

Learning about Native American cultures is the most effective way to create positive counselor/client relationships and to enhance employment outcomes for the client. Because of cultural differences and the postcolonial issues faced by Native people, the Native American client presents unique challenges for a counselor. Being aware of the issues discussed in this lesson will alert the counselor to things to look for, different methods of responding, proper manners, and polite cultural gestures. Being aware and practicing these things help increase the respect and honor the Native American client will show the counselor.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

17. Which of the following statements is *not* correct:

A. Lack of cultural understanding is cited by Native American clients as the greatest impediment to interacting with service providers.

B. There is It was not until the Indian Civil Rights Act of 1968 and the Indian Self-Determination and Educational Assistance Act of 1975 that both the right of citizenship and the right to vote in national elections were solidified.

C. Traditional leadership systems are rare in tribal life.

D. Tribal people often cling their traditional cultural and spiritual values, while integrating new ways into the old as well as using the new to preserve the old.

18. All of the following are underlying spiritual beliefs of traditional Native American cultures mentioned by the author, *except:*

A. All humans are brothers and sisters, and all creations are relatives.

B. Things happen by accident; not all things have a reason and a cause.

C. Reasons are often spiritual, though causes are often both spiritual and physical.

D. People must learn the lessons they came to this life to learn and teach what they came to teach.

19. Which of the following statements is/are correct?

I. Postcolonization Stress Disorder refers to the emotional and psychological trauma caused by the anger, grief, and hopelessness created by being members of conquered nations.

II. Clients with any traumatic stress disorder are likely to have a personal history of substance abuse, poor educational and vocational records, and poor interpersonal skills.

III. Determining whether a client has postcolonization stress disorder is best achieved by taking a personal history.

A. I and III

B. II and III

C. I, II, and III

D. II only

20. The author offers which of the following as an important tip for effectively counseling Native American clients:

A. Staring straight into a client's eyes shows respect.

B. A hard, vigorous handshake is a show of equality and interpersonal harmony.

C. Space and silence for a time at the beginning of the session for the first few meetings allows for each person to sense the essence or spirit of the other.

D. The counselor should offer directions, not merely suggestions.

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Directions in Rehabilitation Counseling

Volume 9 Lesson 6

Providing Vocational Services to Clients in Substance Abuse Rehabilitation

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Background

Substance abuse is one of the most important health care issues of this decade. **Estimates indicate that 5.5 million individuals, or slightly more than 2.5% of the adolescent and adult U.S. population, need treatment for substance abuse**. Not only are enormous psychological and emotional costs exacted from these individuals and their families, but the toll on other families directly or indirectly caused by substance and alcohol abuse is enormous. Entire communities are significantly affected by substance abuse. Society as a whole is affected by the destruction of common property, violent crime, incarceration, a burdened justice system, and rising health care costs.[1]

Substance abuse has cost business and industry millions of dollars. **Reports indicate that, in 1990 alone, alcohol abuse and dependence costed Americans $136.3 billion**.[2] Gerstein and Harwood[3] report that the "largest economic impact of drug abusers derives from their abandoning the legitimate economy for the underground one and their potentially impaired performance in legitimate jobs." **A significant amount of the cost to businesses is caused by the effects of substance abuse on work performance: increased absenteeism, decreased work productivity,[4] lateness, employee theft, and increased workplace accidents resulting in injury and death.**[5]

Studies of the life histories of individuals with substance abuse disabilities reveal that their paths to recovery are complicated and lengthy, often characterized by relapse. Individuals with severe substance abuse problems take significantly longer to rehabilitate and are more prone to fragmenting their recovery, relapsing frequently. **Many recovering abusers are so damaged by previous substance abuse that without the benefit of psychological, pharmacologic, social, and economic interventions, they will lack fundamental behavioral and coping skills.**

Some of the psychological and emotional costs are caused by impaired job performance and subsequent unemployment.[2] In a society where the absence of work may severely damage a person's identity, status, and self-worth,[3] unemployment may lead to greater abuse of substances.[4] On the other hand, unemployment may motivate the individual to seek help. **Because the relationships between substance abuse and employment or unemployment are significant and dynamic, vocational needs must be addressed in treatment programs.**

This lesson will focus on a holistic approach to vocational rehabilitation for consumers with substance abuse disabilities. The delivery of such services will be addressed. Strategies to overcome obstacles to the delivery of these services will be offered.

Substance Abuse and Employment

Senay, Dorus, and Joseph[5] reported that over half of all individuals seeking treatment for polydrug dependence indicated employment difficulties as the primary reason for doing so, and nearly three-quarters of the sample needed employment services at the time of admission. Low income is also a problem for substance abusers. In 1988, the Research Triangle Institute for the National Institute on Drug Abuse (NIDA) conducted a survey of 5,719 adults and 3,095 adolescents.[6] Based on their patterns of consumption of illegal substances, individuals were categorized according to clear, probable, or possible need for treatment. In the group with a clear need for treatment, a substantial majority of the adults (75%) maintained jobs in the legitimate economy. However, many had low incomes: 32% earned less than $9,000 per year, 38.9% earned between $9,000–$20,000, and only 30% earned more than $20,000.

Although large numbers of individuals with substance abuse disabilities maintain employment, their work histories are often erratic, with periods of productivity interspersed with frequent periods of unemployment. Irregular work history and productivity are usually accounted for by bouts of escalated substance abuse, health problems, and encounters with the law. Many individuals with a substance abuse disability use vacations and sick leave to enter short-term, in-patient rehabilitation programs when their abuse escalates. However, many individuals become overwhelmed by their substance abuse disability and leave the legitimate labor market when they are no longer able to balance the demands of work with the escalating demands for drugs. At this point, their primary income source becomes the illegitimate market: crime.

Other substance abusers, approximately 10%, have few meaningful or successful work experiences.[7] Many have marginal or poor records of education and employment. **This group includes those who have not completed high school, have no work skills, and have held only short-term, unskilled jobs. Many have complex medical and social problems and a history of numerous arrests and convictions.** These individuals are frequently alone, separated from friends and family; many have had numerous treatment experiences without any long-term success.

Functional Limitations of Individuals with a Substance-Abuse Disability

Functional limitations have been defined as consequences of health problems that leave an individual unable to meet set standards of anatomical, psychological, physiological, or mental performance.[9] Mental and physical complications of chronic use are common; **substance abuse can have an impact on critical neurologic, metabolic, cognitive, and cardiovascular functions.** Individuals recovering from substance abuse may experience a wide range of functional limitations. The limitations may be transitory and diminish as recovery progresses (e.g., depression, short attention span) or they may be permanent and the result of chronic abuse (e.g., memory loss, impaired cognitive functioning). **Since the nature and severity of a person's limitations will affect the planning, delivery, and outcome of his or her rehabilitation services, the assessment of functional limitations should be an integral part of the rehabilitation process.**[10]

CAUSAL FACTORS:

The etiology of functional limitations is diverse. **Functional limitations may be a result, directly or indirectly, of substance abuse or may be extrinsic or environmentally caused.**

Functional limitations that are direct consequences of substance abuse are described by Pape's[11] Post Acute Withdrawal Syndrome. The syndrome is characterized by poor abstract reasoning, low tolerance for stress, and exaggerated mood swings. Limitations caused by abuse syndromes include neurologic and cognitive deficits which affect memory, concentration, and information processing.[9]

Functional limitations that are indirect consequences of substance abuse appear in a variety of conditions and can affect mobility, communication, and neurologic functions. They are often the result of accidents due to negligence or injurious behavior. Incidents of traumatic brain injury have a high correlation with substance abuse.[12,13]

Extrinsic or environmentally caused functional limitations include barriers that the individual may face in obtaining employment and accessing certain social services. Extrinsic limiting factors may be found in the myriad of social conditions that surround abuse, such as poverty, familial dysfunction, and limited educational opportunities.[1] These external conditions are part of the individuals background and frame of reference and have helped direct and/or caused actions, behaviors, and feelings. **It is critical that the counselor understand the factors in the person's life that impact present functioning. He or she should work with the consumer to eliminate or modify those factors that can be changed and to find more successful ways of working within conditions that are more static.** Additionally, the counselor should help the consumer to not feel bound or limited by negative conditions.

ASSESSMENT MODELS:

Livneh and Male (1993),[9] **in creating a model to identify functional limitations, postulated that there are six realms in which functional limitations manifest. Substance abuse is one of the causative factors in three of the realms. The first is the cognitive-affective realm, in which limitations are manifested by an inability to stay on task, lack of judgement when presented with choices, poor motivation, lack of energy, poor impulse control, and poor decision-making and problem-solving skills. The second is the cognitive-processing realm, in which functional limitations may appear as below average intelligence, a diminished ability to intake and process new information, and impaired memory. The third is the social-affective realm, in which limitations occur in forming and maintaining meaningful, rewarding, and safe relationships.**

Wright's philosophy of somatopsychology is another model for understanding functional limitations.[14] Critical components of this theory are that persons who abuse drugs have to admit to being different from people who do not abuse drugs and have to acknowledge the losses caused by their substance abuse. Only by accepting their differences and losses can individuals become open to situations that can minimize their loss, enhance self-acceptance, increase motivation, and enlarge their value systems; this ultimately will help them to cope more effectively with challenges.

Functional limitations can become significant obstacles to individuals' recoveries, diminishing their belief in their ability to regain competitive and independent functioning, including functioning in the workplace. Rehabilitation practitioners and their clients are constantly challenged to distinguish the etiology of functional limitations and prescribed interventions. **However, unless the full range of functional limitations are recognized and addressed, the rehabilitation process cannot work to the maximum advantage of the individual.** Individuals not only need to address their limitations and to learn to work within them, they also must learn to capitalize on their capacities.

The Holistic Rehabilitation Model

The rehabilitation concept is based on a theoretical model which determines the issues to be addressed and thus directs the focus and determines the direction of the process. **Initially, rehabilitation theory was founded on a medical model that addressed the physiological function** (or dysfunction) **of a patient's body; the body was fractioned into its various parts for study and treatment. Practitioners, believing that rehabilitation could occur only at the physical level, considered consumers' environments, emotions, and subjective interpretations irrelevant to the rehabilitation process.**[15]

Finding this model lacking, rehabilitation counselors advocated that specialists consider other systems of the consumer as well.[16] **Research indicated that emotions and psychodynamics were integral to the functioning of the human body. Consequently, the term "client" replaced "patient."** Social workers were added to the rehabilitation team to address the broader interpersonal and societal dimensions of clients' environments, and psychologists were added to meet clients' mental and emotional needs.[5] **Vocational counselors joined the team to address clients' educational and vocational needs.**[16]

A biopsychosocial model was developed to serve as a framework for a comprehensive rehabilitation approach. The rehabilitation practitioner was responsible for working with the whole person, addressing each individual's emotional, mental, physical, and environmental needs. Accordingly, a "client" became a "consumer" of services.

Recently, the field of rehabilitation has become concerned that the biopsychosocial model still fails to address the consumer's spirituality. **Goodwin[16] proposed a holistic model, which considers a person's physical, mental, *and* spiritual dimension within his or her environmental context. He defined spirituality as "beliefs associated with meanings of life"[p.31] and distinguished it from religion, which is one form used to express spiritual beliefs.** Trieschmann[5] advocated that spirituality can and must be integrated into the rehabilitation process without being tied to any particular dogma.

In 1993, a training manual for Collaborative Short-term Training in Addiction Rehabilitation (Co-STAR),[5] a demonstration project funded by the U.S. Department of Education Rehabilitation Services Administration, included spiritual factors along with the biological, psychological, and social components. **The Co-STAR training model defined spirituality as individuals' "principles and values and higher needs, such as love, creative expression, freedom, purpose, and community."[p.19]** The holistic model adds spirituality to the biopsychosocial model.

The holistic rehabilitation model is appropriate for consumers with any disability, but it is particularly relevant for individuals with a substance abuse disability. **McCarthy[19] points out that the most obvious connection between rehabilitation and spirituality occurs with this client population.** Since their development by Alcoholics Anonymous (AA), spiritually-based 12-step models have become inseparable from the larger substance abuse field. Their strong spiritual components appear to address a need among recovering substance abusers that neither the medical nor the biopsychosocial model alone seem able to fulfill.

When rehabilitation practitioners adopt a holistic model, their perceptions of substance abuse as a disability change. Because the model offers a better framework for understanding the onset of substance abuse, its progression, its treatment, and abusers' vulnerability to relapse,[20] service delivery and treatment outcomes also have changed. In the holistic rehabilitation process, the individual with a substance abuse disability is an integral participant.

CHARACTERISTICS OF A HOLISTIC VOCATIONAL REHABILITATION APPROACH:

Rehabilitation counseling and the counseling relationship serve as the foundation for ongoing vocational exploration, goal setting, and action toward the goal. Rehabilitation services give individuals with a substance abuse disability the opportunity to participate in an evaluation of all areas of development and functioning, including medical, social, psychological, vocational, legal, economic, and spiritual factors, as well as assessments of academic and skill potential.

The most effective vocational rehabilitation approach with substance abusers in treatment is holistic, individualized, and consumer-oriented, and is focused on empowering individuals to make decisions regarding their personal values and needs in preparation for the development and achievement of short- and long-term goals. The holistic vocational rehabilitation model does not minimize either the complexity of a substance abuse disability or the individual's susceptibility to relapse. Instead, it recognizes that recovery is a lifetime challenge for the consumer and thus guides a person throughout difficult periods in initial treatment and supports his or her efforts to maintain recovery and take steps toward independence.

The vocational rehabilitation process begins with an individual's agreement that he or she will try to benefit from the process by defining changes in his or her life. Whether the consumer's goal is a GED, skill acquisition, or post-secondary education, his or her unique needs and capabilities are integral to the assessment and planning process. **Some individuals, unaware of their values and needs and of the rehabilitation options available to them, need guidance and instruction offered by the holistic rehabilitation process.**

The vocational rehabilitation counselor provides the consumer with services based on a thorough assessment of his or her functional capacities and limitations as determined by a classification system or a comparable assessment tool that evaluates biological, social, psychological, and spiritual dimensions. **Assessment is ongoing and requires the complete participation of the consumer as well as his or her continuous expression and definition of personal goals and objectives.**

The goals of the individualized plan are to help the consumer build confidence, gain experience in managing activities of daily living without reliance on drugs, evaluate his or her strengths and weaknesses, and prepare for employment that is meaningful and in accordance with his or her values, goals, and needs. Once goals are clarified, the rehabilitation process provides opportunities for situational assessments. Through volunteer assignments or on-the-job training opportunities, the consumer can learn about work, test out work behaviors, and receive evaluation and feedback. Individuals become educated or reintroduced to the world of work, career choices, challenges, and opportunities. They explore issues of competition in the workplace and are helped to prepare for it. Each consumer is continuously encouraged to assess personal goals in the context of societal norms and expectations in order to arrive at conclusions about his or her choices and their possible consequences.

A consumer's entrance or return to employment is best accomplished when the steps described above are completed. These steps, specific to each individual and completed sequentially, help individuals with substance abuse disabilities make successful transitions emotionally, socially, educationally, spiritually, and vocationally. Appendix 1 offers an outline of steps for the rehabilitation counselor to follow.

Substance Abuse and Vocational Rehabilitation

The vocational rehabilitation counselor, as a member of the rehabilitation team, works closely with individuals with substance abuse disabilities to identify the necessary rehabilitation services. In this role, the counselor may be involved in the entire continuum of the rehabilitation process, from assessment and treatment plan development through resource coordination, counseling, and client advocacy.[19]

THE IMPORTANCE OF EMPLOYMENT AS A TREATMENT OUTCOME:

Legitimate employment is a critical factor in the rehabilitation process. Since unemployment and vocational instability have been associated with individuals who abuse substances, gainful employment may be seen as an indicator of successful adjustment, social functioning, and community reintegration.[2] **Employment, therefore, often is used to measure treatment success and guage how well an individual is functioning in his or her community environment.**[22]

Because it symbolizes meaningful contribution to the community and the larger society, employment is crucial to the development of a healthy sense of self;[2] **the occurrence and severity of relapse tends to be lessened in individuals who are able to develop positive self-images and raise their self-esteems through gainful employment.**[23,24] **Studies have shown that increased financial earnings are associated with increased independence, community integration, greater self-esteem, greater perceived control and positive long-term treatment outcomes.**[24-27] Gainful employment also is associated with decreased criminal behavior and substance abuse[27] which implies savings to the justice system. Additionally, employment reduces health care and public assistance costs.

THE ROLE OF VOCATIONAL REHABILITATION:

The goal of the vocational rehabilitation process is to maximize independent functioning through gainful

employment. Vocational rehabilitation aims to improve disabled individuals' abilities to obtain and maintain employment consistent with an individual's values, life goals, skills, abilities, knowledge, and interests.[16] In order to develop short- and long-range goals, the rehabilitation counselor assesses the individual, designs plans to achieve goals, and provides a wide range of vocational, educational, supportive, and follow-up services. **The rehabilitation counselor assists in recognizing and compensating for limitations and maximizing the consumer's capacities; facilitates acknowledging and diminishing the consumer's sense of loss; and helps develop the motivation to maintain a substance-free and independent existence.**

To assist in recognizing and compensating for limitations and maximing capacities, the counselor should guide the consumer through a process of self-discovery and esteem and skill building. It is important that the consumer gain a realistic understanding of self upon which to base future plans and actions. **To facilitate the acknowledgement and diminishment of the sense of loss, the counselor must be aware that the consumer's cessation of substance abuse carries with it feelings of lost power and euphoria as well as a loss of escape mechanisms.** Further, it marks a seperation from a lifestyle to which he or she is accustomed and from relationships associated with that lifestyle. The consumer often feels vulnerable and at an emotional and practical loss regarding feelings, behaviors, time, money, and interpersonal interaction. The counselor should attempt to aid the consumer in developing new ways of filling their time as well as new methods for developing relationships. The goal of building skills and securing employment will go a long way to help the consumer to overcome these losses. To help the consumer feel increasingly independent, the counselor must encourage a life without a concentration on substances. The counselor should accentuate the consumer's achievement of any satisfaction or accomplishment, such as making decisions, keeping appointments, talking honestly, admitting fears, and developing new skills. Any such achievements foster independence and a growing realization that it is possible to pursue a more complete and fulfilling life.

Delivery of Services

Vocational rehabilitation services are delivered in several ways to individuals with a substance abuse disability. Four such ways are outlined below.

First, a substance abuse treatment program may include a part- or full-time vocational rehabilitation counselor among the permanent staff. As staff, a vocational rehabilitation counselor participates in all treatment planning and has key responsibility for delivering a full range of vocational services, either directly or in conjunction with community organizations. **The benefit of this approach is that individuals in recovery can begin to receive habilitation** (as opposed to rehabilitation) **or pre-vocational services early in treatment; rehabilitation issues can be addressed early in an effort to enhance individuals' self-esteem; and preparations for long-range plans can be formed as the rehabilitation process develops.** When clinically appropriate, individuals may be referred to community-based programs or to state vocational rehabilitation agencies. As part of the treatment team, the vocational rehabilitation counselor facilitates the referral process so individuals do not have to negotiate new services alone.

Second, a state vocational rehabilitation agency may provide the vocational services. An individual may be referred to a state agency by the treatment program after his or her clinical assessment has been completed and at a time agreed upon by both agencies. Because state vocational rehabilitation agencies usually serve large numbers of individuals, they assess consumers' needs and readiness for rehabilitation before providing an array of vocational services. **State agency readiness requirements may not be appropriate for individuals early in recovery and treatment. To develop readiness for state vocational rehabilitation services, these individuals may need additional psychosocial and pre-vocational development.**

Third, community-based agencies may provide vocational rehabilitation services to individuals in treatment. These agencies usually focus on particular populations, such as individuals with substance abuse disabilities, and provide assessment, evaluation, and intervention, including pre-vocational and vocational services. They also may refer clients to the state vocational rehabilitation systems.

Fourth, a treatment program may provide vocational rehabilitation services as part of its social services. Vocational services are usually provided by individuals' primary counselors. **In this approach, consumers who are motivated can benefit from counseling support and direction, but those in need of a more carefully planned approach may not be adequately assisted.** To improve services, the counselor should focus as much as possible on the needs of each consumer as an individual and help him or her gain access to community-based vocational and educational resources. Programs can assist by urging counselors to attend in-service training programs that are geared to the delivery of vocational services. Counselor skills should be assessed to determine who is best equipped to lead structured group activities for consumers. Guides for group activities related to employment are available through companies such as JIST. Such companies also have career resources that can become part of the program's library. Linkages to neighborhood employers and services expand the oppurtunities and resources available to the consumer.

Obstacles to Delivery of Services

There are several obstacles to the successful delivery of vocational rehabilitation services. **These include societal prejudices, insufficient or unavailable treatment programs, problems in the client population, and the interplay between these factors.**

SOCIETAL PREJUDICES:

In society, substance abuse continues to be attributed to a lack of willpower, to an inability or unwillingness to change immoral decisions and discard indiscriminate behaviors. This is known as the moral model.[28] Societal prejudices limit employment opportunities for recovering substance abusers; potential employers shy away from hiring qualified individuals if they suspect or know that the applicants have histories of substance abuse. Belief in the moral model also affects legislation, funding of services, and prioritization of needs. Substance abuse is criminalized and funding is allocated to criminal justice systems and family courts; funding for treatment and vocational rehabilitation programs often is limited or unavailable.[22,23]

INSUFFICIENT OR UNAVAILABLE TREATMENT PROGRAMS:

Insufficient or unavailable substance abuse treatment programs also create obstructions for recovering consumers who are substance abusers. Research is needed to identify which vocational rehabilitation interventions and services are most successful for which recovering clients and at what point in treatment. Without such research, the empirical evidence necessary to justify developing new programs and services and/or expanding existing ones is lacking. In addition, **payment for most substance abuse programs depends on Medicaid reimbursements; vocational rehabilitation services, however, are not billable under this government program.** The limited programs and services available may not always meet the special vocational needs of an individual with a substance abuse disability. Additionally, many existing treatment programs give low priority to the vocational and educational needs of clients; other perceived needs take precedence. Many programs do not employ vocational rehabilitation counselors or do not provide adequate staff training in vocational rehabilitation. As such, they often are not able to make appropriate assessments and referrals.[24]

When vocational rehabilitation counselors work in substance abuse treatment facilities, they often face several obstacles. **Lack of institutional support often translates into limited financial resources for these counselors and their services and may translate into lack of support by other staff members.** If perceived as interfering with an individual's treatment plan, vocational rehabilitation services and referrals may be undercut by other team participants. In addition, the structure of a treatment program may be so rigid that it interferes with the delivery of vocational rehabilitation and educational services. **A busy program structure may limit, or even eliminate, the time allotted for vocational services.** These barriers can be overcome by education of senior service staff about about the benefits of vocational rehabilitation services for consumer outcomes. With the recent advent of welfare reform and workfare initiatives as well as managed care, treatment programs are experiencing external pressure to readjust their programs so that they offer vocational services with measureable outcomes. Program funding will be based on outcomes. Counse-

Table 1
FACTORS UNDERLYING OBSTACLES

Obstacles to obtaining marketable skills
- Need for immediate gratification (vocational training is seen as too lengthy and time-consuming)
- Lack of realistic vocational goals
- Low educational levels
- Lack of skills as a learner (e.g., punctuality, attendance, respect for authority, asking questions, following instructions, problem-solving)
- Low self-esteem
- Fear of change
- Interpersonal/attitudinal problems
- Unrealistic perceptions and expectations about training environments
- Lack of role models *qua* productive students
- Lack of supportive social network

Obstacles to obtaining employment
- Education and skills deficits
- Low self-esteem (negatively affects motivation, self-presentation in interviews, follow-up after interviews, persistence after several rejections, etc.)
- Interpersonal/attitudinal problems
- Unrealistic perceptions of and expectations about work
- Lack of social support and encouragement
- Focus on immediate gratification
- Lack of interviewing skills and job-search skills
- Negative stereotypes held by employers regarding substance use, criminal history, minorities, etc.
- No (or limited) work history
- No (or limited) employer and/or personal references
- Lack of supportive social network

Obstacles to maintaining employment
- Poor problem-solving skills
- Poor interpersonal skills with coworkers/employers
- Problems accepting criticism and directions
- Problems with punctuality and attendance
- Poor impulse control
- Mistrust of authority figures
- Unwillingness to report problems, incidents
- Competing demands (childcare, family problems, legal problems)
- Lack of role models
- Relapse to alcohol, drug use, criminal behavior
- Lack of supportive social network

Adapted from: Substance Abuse Disability and Vocational Rehabilitation. Dayton OH: Wright State University, RRTC, 1996. Manual. Grant from NIDRR.

lors and consumers could initiate change in the existing services by advocating for services to meet vocational needs.

Counselors' attitudes may also affect service delivery, especially in state vocational rehabilitation agencies. Many counselors still attribute substance abuse to an absence of willpower and morals. **Consequently, counselors sometimes view other disabilities as more legitimate and prioritize service delivery and funding for those populations.** In addition, many agencies are allocated insufficient funds for training programs, particularly for long-term training programs targeted at individuals with substance abuse disabilities.[25,26] In-service training can be an effective vehicle for helping counselors learn more about substance abuse and thus help decrease the negative stereotypes that predominate thinking. Training initiatives should focus on biopsychosocial and spiritual-based paradigms in an effort to supplant the moralistic approach.

PROBLEMS IN THE CLIENT POPULATION:

In individual clients, the intrinsic and extrinsic functional limitations and coexisting disablities described earlier may manifest as a host of problems.[21] The dominant obstacles experienced by individuals with substance abuse disabilities occur in three vocational areas: obtaining marketable skills, obtaining employment, and maintaining employment (See Table 1).

The frequent coexistence of another disability may result in additional obstacles or limitations. These limitations may increase the challenges faced in entering and successfully completing treatment as well as preparing for, obtaining, and maintaining employment. Individuals with coexisting disabilities are often viewed by counselors as overwhelming challenges. Specialized training in understanding factors related to coexisting disabilities and how to minimize and overcome resultant barriers can serve to enhance outcomes. The consumer

Table 2
VOCATIONAL REHABILITATION STATUS POSSIBILITIES

Not appropriate for vocational rehabilitation services:
Abusing drugs and alcohol; unwilling to enter treatment
Appropriate for habilitation services:
Has poorly developed adult daily living skills
Appropriate for rehabilitation services:
Needs to define and focus on alternatives to abuse
Appropriate for vocational evaluation:
Vocationally confused, questionable academic levels
Appropriate for counseling and guidance only:
Needs to explore values and to redefine self as a drug-free person
Appropriate for pre-vocational services:
Needs to develop work skills, explore skill areas
Appropriate for career planning:
Transition from drug-centered life to goal-oriented employment
Appropriate for training:
Has specific, confirmed, and appropriate goals
Appropriate for placement:
Needs guidance to structure job search and to deal with drug-related past
Appropriate for follow-up:
Needs to learn to recognize and manage triggers

[Table taken from Substance Abuse Disability and Vocational Rehabilitation. Dayton OH: Wright State University, RRTC, 1996. Manual. Grant from NIDRR.]

will benefit from accomodations to these disabilities in training sites as well as in the workplace.

The financial disincentive experienced by the individual receiving home relief (e.g., Supplemental Security Insurance [SSI] or Social Security Disability Insurance [SSDI] income replacement programs) **presents an additional, and common, obstacle. For individuals with deep feelings of insecurity and a history of failure, the security of a check, a place to live, food on the table, and medical care become very comfortable—so comfortable that they become trapped, dependent on both the income and the related medicaid assistance.** Not wanting to give up this aid in the face of uncertain prospects for becoming self-supportive is an obstacle to taking the steps necessary to escape. Individuals who do pursue vocational rehabilitation often experience a great deal of anxiety when these benefits cease. The best way to allay these fears is to instill in the consumer a trust that the services he or she is receiving will be of ultimate benefit and that he or she is capable of maintaining employment.

Many substance abusers do not clearly understand that rehabilitation is a process; as such, it is most effective when interventions are both well-planned and sequential. Table 2 is a guideline for appropriate interventions. Breaking down the process of rehabilitation into sequential, ordered steps toward the goal is especially important because it allows an individual to experience small gains on the path toward more significant changes. Lacking an understanding of the step-by-step nature of the process, an individual, impatient to make gains, might miss out on the development of skills ultimately beneficial to the successful achievement of his or her goals.

The vocational rehabilitation process helps the consumer understand the obstacles he or she may encounter, whether they be societal, programmatic, personal, or some combination of these. Understanding how the obstacles prevent movement can help the consumer develop a sense of self-esteem and control, which, in turn, can enable him or her to move ahead in the process and act more assertively.

Who Benefits From Vocational Services?

Individuals who can benefit from vocational services fall into two basic categories based on their employment and educational backgrounds and current independent functionings. **The first group includes those individuals who enter treatment with a history of some work accomplishment. For these individuals, the most effective vocational services are those that help assess the impact of their abuse on their lives in general and on their work performance in particular.** Some may be concerned that they will not be able to maintain their work performance without the benefit of drugs. **The holistic vocational rehabilitation approach assists these consumers to gain self-confidence and find personally compelling reasons to attain gratification from**

work and other experiences made possible through stable and secure employment.

Some have been able to maintain their abuse and their work life. They frequently enter treatment when their abuse has destroyed or significantly impeded their ability to work and function independently. These individuals report having lost control, focus, and even themselves to drugs and a drug-focused life. They often have lost their jobs, families, money, homes, self-respect, and self-esteem.[3] **Because many in this first group consider their careers or their specific work environments as substance abuse-enabling** (e.g., due to such work conditions as high stress, long periods of time away from home, and settings where drug use and abuse are the norm)**, they frequently choose not to continue in their previous professions. Vocational services focus on identifying their transferability to other professions.** Whether or not a career change is indicated, these individuals must commit to drug-free lives, examine the patterns and triggers that lead to abuse, gain the strength to overcome drug-related urges, and develop and practice well thought-out coping strategies to manage stressful situations. Continuous and detailed self-assessment, often accompanied by ongoing psychotherapy and participation in a self-help program, helps consumers become able to return to employment and renew their focus on responsibilities and opportunities in their careers.

For those who have maintained relatively high levels of work performance despite substance abuse, rehabilitation focuses on examining the effects of their substance abuse on personal and professional expectations. These individuals frequently experience shame and embarrassment because of failures to self, society, and family; their concerns about disgracing themselves and their families are addressed in treatment. **They also evaluate their roles as workers/professionals, re-evaluate their original career aspirations, and identify stategies to integrate their recovery and rehabilitation process into their business and community identities.** Self-exploration gives them ample opportunity to reflect on, redefine, and re-establish personal standards—often setting new personal standards, acquiring new friends and associates, and building new bonds that maintain self-esteem.

The second category of consumers who benefit from vocational services have had no substantial work experiences, fewer periods of sustained employment, and often have been fired or quit jobs because of substance abuse. They may lack role models in the workplace; their families may have generational patterns of low levels of employment. They may have unrealistic concepts about work and themselves as workers. Their coping skills may be weak and their interpersonal skills undeveloped. For these consumers, work may generate feelings of inadequacy and fear, and their lifestyle choices may not be associated with or dependent on sustained employment. Many of these consumers enter or re-enter the labor market feeling overwhelmed.[3] Their lack of success, limited work experience, and low aspirations may negatively impact their rehabilitation and impede their success in treatment.

Vocational rehabilitation services for individuals who have received previous vocational or academic training and have experienced some periods of sustained employment should focus on assessing residual functional capacities and limitations, enhancing their self-esteem as workers, and gradually reintroducing them to work with the long-term goal of stable employment. Retraining, situational assessments, and volunteer assignments may help build skills and confidence.

The individuals in this second category present very complex sets of needs encompassing many personal, social, medical, psychological, vocational, and legal problems. Aside from histories of transitory, dead-end jobs and life experiences primarily focused on drugs and supporting drug lifestyles, many have lengthy records of encounters with the law enforcement system or periods of incarceration. Minimal educational or vocational achievements or deficits in basic cognitive skills and/or learning disabilities may complicate rehabilitation. **These consumers may be separated from family and community, and may require an extensive array of structured and supportive habilitation services to make them capable of independent living for the first time.**[5]

Vocational rehabilitation is not appropriate for all individuals with a substance abuse disability. Some individuals in treatment are already able to continue their independent functioning, including employment. Others have such severe medical, emotional, social and/or

family problems that they are not appropriate candidates for vocational rehabilitation until these issues are addressed. Still others cannot acknowledge their need for vocational rehabilitation. **It is critical, however, that the vocational and educational status of all potential consumers be evaluated and that all be afforded the opportunity to benefit from vocational rehabilitation services consistent with their identified needs and the availability of appropriate resources.**

Conclusion

The holistic vocational rehabilitation approach emphasizes the actualization of short-term results in an effort to achieve long-term goals. **Consumers are assisted in making gradual, positive steps toward rehabilitation**. Often, they must be encouraged to fulfill basic treatment commitments while participating in vocational activities. The specific focus on substance abuse and its impact on each person is critical. **As consumers begin to understand their patterns of abuse and are helped to establish an improved sense of self, their personal insight becomes the foundation for decisions regarding their roles and functions in society and in the workplace.**

A holistic vocational rehabilitation approach also supports collaboration with substance abuse treatment programs and other human service providers in the community. **Throughout the rehabilitation process, consumers are encouraged and taught how to be advocates for themselves.** The roles of the family, significant others, and the environment in promoting a consumer's recovery and rehabilitation are emphasized and supported; the ultimate goal is total community reintegration.

In planning for the delivery of vocational services, it is first necessary to evaluate the population. Of particular concern are the needs of each individual. Essential to determining those needs is an understanding of the nature and length of treatment programs. **Vocational services should be integrated into substance abuse treatment, and vocational staff should be part of the treatment team.** Likewise, a wide range of vocational resources and services are offered through community organizations and state and federal systems.

Many social issues confronting society today are linked to substance abuse. The more we come to understand the complexities of the lives of the most needy, the more we see the ravages of substance abuse as a component in the unraveling of human lives and the despair that surrounds individuals and their families and ultimately society as a whole. The economic, social, spiritual, and psychological tolls are enormous.

Attention must be paid to the concept that individuals want to change and can change. Vocational rehabilitation is certainly not the only answer to the problems of substance abuse. The best avenue for change, however, comes in helping individuals with substance abuse disorders attain employment. If we believe that individuals want to work and to contribute to society, then there need to be vehicles to help those who need help to achieve that goal.

Appendix I

The Job Placement Process: A Guide for Counselors

INTRODUCTION — Get to know the person's:

- Prior experience
- Skills and knowledge
- History of firings and promotions
- Record of job tenure
- Salary history
- Means of securing employment
- Personal skills: dress, speech, time management, physical appearance, legal issues, medical problems
- Length of time in recovery from substance abuse
- Legal history

ASSESSMENT — Evaluate appropriateness for return to work and specific career choices based on:

- Qualifications for specific jobs
- Nature of work environments
- Personal appearance
- Personal strengths
- Recovery status
- Realistic understanding of work
- Ability to seek employment, complete application, interview appropriately
- Communication skills at all organizational levels
- Ability to handle stress, challenges, decision-making

TO TELL OR NOT TO TELL — Counsel regarding self-disclosure:

- Whether to or not and if yes, how to disclose substance abuse history
  based upon application and interview requirements
- Explaining work history; gaps, frequent changes, terminations
- History of convictions and incarcerations

WORLD OF WORK — Facilitate realistic knowledge of work:

- Recognizing demands of work in general, and of specific jobs in particular
- Managing transition to work
- Emphasizing work with people, data, things; indoor/outdoor; travel/stationary
- Considering structured vs. unstructured work
- Getting along with bosses and co-workers
- Traveling to and from work
- Managing money
- Managing time
- Identifying relapse triggers and maintaining sobriety
- Developing and maintaining supportive relationships
- Responding to social demands of a job
- Obtaining required licensure or certification
- Isolation from co-workers
- Isolation from the job peers
- Extent and nature of supervision

EMPLOYABILITY — Assess skills for choosing job:

- Making a career choice
- Assessing presence of requisite abilities and experience
- Considering employment options
- Identifying non-enabling environments

RESOURCE DEVELOPMENT — Identify opportunities:

- Accessing job openings
- Seeking help from professionals and employment agencies
- Responding to ads
- Networking with friends and family
- Attending job fairs
- Receiving information by mail
- Conducting employment related research in the library

JOB SEARCH — Develop job seeking skills:

- Learning where to find leads
- Identifying the appropriateness of openings
- Completing applications (especially questions related to incarceration, reasons for leaving, gaps in employment)
- Positive interviewing skills
- Accepting a job
- Negotiating salary, terms and conditions of employment

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

21. According to the lesson, which one of the following statements is *not* correct?

A. The most effective vocational rehabilitation approach with substance abusers in treatment is holistic, individualized, and consumer-oriented.

B. Studies show that increased financial earnings are associated with positive long-term treatment outcomes.

C. Community-based agencies usually focus on particular populations and provide assessment, evaluation, and intervention.

D. Initially, rehabilitation theory was founded on a psychosocial model which focused on an indiviudual's broader interpersonal and societal dimensions.

22. According to the authors, obstacles to obtaining employment include all of the following *except*:

A. Unrealistic perceptions and expectations about work.

B. Negative stereotypes held by employers regarding substance use, criminal history, and minorities.

C. Lack of realistic vocational goals.

D. Focus on immediate gratification.

23. Which of the following statements is *not* correct:

A. Functional limitations are defined as consequences of health problems that leave an individual unable to meet set standards of anatomical, psychological, physiological, or mental performance.

B. Functional limitations that are direct consequences of substance abuse are described by Pape's Post Acute Withdrawal Syndrome.

C. According to Wright's philosophy of somatopsychology, persons who abuse drugs have to admit to being different from persons who do not, and have to acknowledge the losses caused by their substance abuse.

D. Even though the nature and severity of a person's limitations will effect the planning, delivery, and outcome of his or her rehabilitation services, the assessment of functional limitations does not have to be an integral part of the rehabilitation process.

24. According to the authors, which of the following is *not* an obstacle to the delivery of services:

A. In society, substance abuse is viewed according to a moral model; it is viewed as a lack of willpower.

B. Counselors sometimes view other disabilities as more legitimate and prioritize service delivery and funding for those populations.

C. The rehabilitation counselor too often focuses on the sequential, step-by-step nature of the process at the expense of stressing the need for the consumer to make significant changes.

D. A consumer receiving financial assistance such as SSI or SSDI often will not wish to give it up due to the security it provides.

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Directions in Rehabilitation Counseling

Volume 9 Lesson 7

Treatment of Comorbid Posttraumatic Stress Disorder and Substance Abuse

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Introduction

Over the past decade, there has been a growing recognition that there is a high co-occurrence of posttraumatic stress disorder (PTSD) and substance abuse (SA) in individuals seeking treatment at mental health and rehabilitation facilities. Incidence estimates suggest the rates of substance abuse in persons with PTSD may be as high as 60%–80%, while the rates of PTSD in substance abusers is 40%–60%;[1,2] PTSD may be under diagnosed by in substance abuse facilities.[3]

PTSD was first acknowledged as a psychiatric problem in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*,[4] but similar symptoms were found among Revolutionary War and Civil War soldiers and among sexually abused women as early as the 18th century.[5] PTSD occurs when a traumatic event leaves such a strong psychic impression that a person later experiences recurrent, painful, and intrusive memories. To avoid re-experiencing the anxiety and pain of the original event, many traumatized persons will avoid activities that may trigger recollections. Consequently, emotional numbing and psychological amnesia to parts or all of the event may occur. Other symptoms may include nightmares, sleep disturbance, hyper-alertness, exaggerated startle, chronic irritability, and reduced ability to concentrate. Among the conditions that commonly co-occur with PTSD are major depression, anxiety disorders, and substance abuse.[6]

This lesson provides an overview of current theories and clinical practices in the treatment of clients presenting with comorbid PTSD and substance abuse. An argument will be made for combining techniques used to treat each disorder into an integrated treatment program which considers the similarities, differences, and interactions between

PTSD and substance abuse symptoms. Three models of PTSD/substance abuse interdependence are summarized and process components important to combination therapy are discussed. Some initial strategies that increase coping skills or ego resources are detailed and trauma process methods are reviewed. This lesson discusses strategies for counselors to facilitate and use group cohesion and progress factors to increase the possibility of positive and longer-lasting outcomes.

The Relationship Between PTSD and Substance Abuse

There is a need to provide comprehensive treatment for clients with dual PTSD and SA diagnoses. Although the criteria in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*,[1] are useful in differentiating between disorders, they do not address treatment priority or interaction effects. **In this context, the counselor must assess each disorder separately without knowing how one may alter the other and choose the disorder which should be the first focus of treatment.**

Traditionally, PTSD and substance abuse have been treated sequentially. Clients have been advised to complete a primary chemical abuse rehabilitation program prior to focusing on PTSD symptoms. However, in practice, those engaged in substance abuse treatment often overlook the dynamics of PTSD as a factor in relapse. PTSD treatment models have overlooked substance abuse relapse prevention or have considered substance abuse behavior side effects of PTSD that will resolve when the PTSD is managed. This often leads to a failure to consider the interplay, or even interdependence, of the two disorders. Treating one disorder while ignoring the other can exacerbate the comorbid condition.

The Dynamics of PTSD and SA—Causal Links and Priorities for Intervention

To formulate appropriate intervention strategies, attempts have been made to determine the temporal or causal links between PTSD and substance abuse. One major school of thought considers substance abuse to be a form of self-medication that has little chance of abetting until the underlying traumatic events are explored, resolved, and managed. This hypothesis implies that chemicals are ingested primarily because of their tension (anxiety) reducing effects.[1] Bell and Khantzian[8] theorize that substance abuse provides a means for the trauma victim to

Table 1
CASE STUDY

Dale S. entered a substance abuse program after 20 years of alcohol and marijuana abuse. His 10-year career as an administrator in a social service agency as well as his 12-year marriage had both recently ended. After a 28-day SA treatment program, he was determined to remain drug- and alcohol-free and improve his life. He found confrontational and directive group therapy to be effective in giving him the discipline to maintain a drug- and alcohol-free lifestyle. However, after four months, he relapsed to drinking binges and marijuana use. He again admitted himself into a substance abuse program.

During this second treatment episode, he began talking to his case manager about traumatic events he experienced while in the military. At 17, he was sexually assaulted by his commanding officer, had a "nervous breakdown," and was released from the military and sent home. For 20 years, he lived with the shame, fear, guilt, and humiliation of what happened. His drinking and marijuana use began soon after the assault, and eventually became habitual. Now, he was at an impasse: Alcohol and drugs no longer helped to alleviate the pain or blur the memories, yet he seemed unable to stop using them. Instead, he found himself alternating between periods of abstinence and periods of indulgence and thrill-seeking.

Dale entered addiction recovery treatment that used cognitive-behavioral strategies for relapse prevention and outpatient group therapy with mild confrontational strategies. During the same period, individual therapy focused on the emotions and cognitions surrounding his traumatic memories. As he explored the emotions of shame, fear, and betrayal inherent in the trauma, he became aware of how he had continued to victimize himself with destructive impulsive behaviors. Through the combination of PTSD and SA interventions, he came to realize how his SA was related to these impulsive behaviors. He began to see how sometimes his SA was caused by the traumatic memories, but at other times, the memories were used to justify his addiction.

re-enact the traumatic event, while numbing the associated emotional pain. **Accordingly, substance abuse may be part of a repertoire of behaviors which trauma victims use to avoid or deny the painful re-experiencing of the original trauma. Through reinforcement and habituation, these behaviors become forms of addiction that are intertwined with the reexperiencing, avoidance, and arousal cycles of PTSD.**[9]

Another model which addresses the dynamics between PTSD and SA proposes that addiction, especially alcoholism, is usually a predisposing condition to PTSD.[10] **According to this model, substance abuse often precedes traumatic experiences and may even set the stage for them to occur.** Consequently, PTSD treatment which does not address the substance abuse lifestyle as the primary problem has little chance of success. Further, substance abuse treatment should be given priority, and trauma therapy should only be considered once addiction recovery reaches a state of sustained remission.

A third model proposes that substance abuse begins after a traumatic event as a form of self-medication to induce sleep and avoid or subdue painful memories, anxiety, and depression.[11] Over time, the PTSD symptoms are no longer suppressed by the substances. The person finds that substance abuse has taken on a larger role in his or her life. Along with the PTSD symptoms, SA symptoms arise, which include overwhelming cravings and needs to use the drug for its own sake, to relieve withdrawal discomfort, and to experience the mood altering effects to which one has become habituated.

Counselors are beginning to focus on similarities and differences in therapeutic strategies used for PTSD and for SA. Recent dual diagnosis treatment protocols have evolved which broaden the scope of treatment by considering the problems interdependent.[12-14] The most basic and practical information provided by these intervention-focused models is that the treatment of comorbid PTSD and SA requires a commitment to and constant focus on abstinence.[15] Both clinical observation and research data show that substance abuse is a strong predictor of negative therapeutic outcomes.[11] This lesson will focus on the treatment of chronic, subacute PTSD and substance abusers who have been detoxed and stabilized.

Although no figures are available, it is probable that substance abuse is a more severe problem for those suffering chronic symptoms of PTSD than for those whose precipitating trauma was recent. Different strategies would be necessary to treat acute exacerbations of PTSD symptoms. It is also worth noting that persons with SA disorder manifest cognitive and memory impairments which could interfere with treatment initiated too soon after abstinence begins.[16]

General Principles Common to PTSD and Substance Abuse Therapy

Therapeutic practice seeks to establish an optimum balance between directive teaching and client-centered insight. **Excessive direction on the part of the counselor can cause the client to be passive, which may slow progress. Singular dependence on client-centered insight may produce circular processing, which may also slow progress. An integrated PTSD/SA treatment program should involve the integration of three basic process components: (*a*) developing a therapeutic alliance, (*b*) guiding clients through self-explorations, and (*c*) engaging the client in new behaviors.**

The first component is to develop a therapeutic alliance that assigns responsibility for change to the client. It is the counselor's responsibility to guide and support that change. The counselor must show the client that taking responsibility for change will be worthwhile. Strategies can be derived from the concepts of self-efficacy and motivational theory.[17]

The second component is to move clients through the process of self-exploration, interpretation, and reframing life experiences. Avoidance behaviors and the denial of addiction are often manifest in patterns of coping that are often extremely difficult for a client to relinquish. Also, the sense of self-efficacy necessary to initiate and sustain positive change is nonexistent in many members of this population. Counselors must remember that resistance is not solely a client-based problem. It also may reflect the counselors' failure to frame the issues and benefits of self-exploration in a way that can help the client overcome his or her fears and hopelessness.[18]

Finally, the third component is to engage the client in new behaviors. Within an integrated PTSD/SA treatment model, two dicta should guide expectations. First, there is no real change without behavioral change. Second, the counselor is not simply a facilitator of change, but rather a promoter of a certain path to change. **The responsibilities of the counselors include teaching new skills, emphasizing the need to act on newly learned behaviors, helping clients generalize behaviors learned in group and individual sessions, and helping them maintain new skills by providing reinforcement episodes and teaching self-reinforcement skills. However, counselors must acknowledge that they are biased in wanting clients to behave in certain ways. It is important for the counselors to be aware of the cultural, personal, class, and contextual biases inherent in their attitudes.** Certain ways of behaving may not be intuitively or even practically beneficial in the world in which a client lives. Thus, respect for the client's current economic status, culture, and environment must temper what type of behavioral change is expected.

Integrating PTSD and Substance Abuse Treatment Strategies

In general, PTSD and SA treatment models differ in terms of how and to what extent they focus on each of the three above mentioned components. Models that concentrate on substance abuse treatment may have little need for direct interventions in self-exploration or reframing life events. Trauma resolution therapy, on the other hand, may focus less on promoting changes in social behaviors or lifestyle. However, integrating PTSD and substance abuse models would necessitate giving equal emphasis to each component of therapy. Guided by these processes, therapeutic techniques and strategies can be utilized to address the symptom-intensification and resistance cycles that PTSD/substance abuse clients commonly display in therapy.

As an initial strategy, it is important that the counselor set expectations and instill confidence in clients concerning their capacity to remain abstinent, learn new skills, and manage compulsive behaviors. Although integrated PTSD and SA treatments require less initial confrontation than many substance abuse treatment regimens, it is important to establish high expectations with clients concerning self-control and their ability to succeed. This can be accomplished in several ways. First, group therapy that provides supportive communication and non-confrontive challenges helps motivate clients to move beyond their fear, shame, and ambivalence. Second, the counselor should focus clients on their strengths and begin to transmit the view that they are survivors, not merely victims.

Other early interventions should serve to establish a relationship of safety and trust; the client should be comfortable discussing anything openly. Both PTSD and SA patients are highly distrustful of those whom they feel cannot understand their problems. They prefer a counselor who has experienced a similar trauma or has been through similar substance abuse cycles. **It is important for the counselor to be as honest and open as possible if he or she has not had similar personal experiences.** At the same time, the counselor can use body language to convey his or her willingness to listen, feel, and understand.

From the beginning of the relationship, the counselor must promote high expectations and teach concrete coping skills to help the client begin building ego resources. **Counselors should teach clients to replace self-destructive coping skills with productive ones through discussion of defenses, cognitive distortions, and affect management.** The counselor may need to confront and challenge old avoidance strategies. Interventions such as the cognitive-behavioral exercises discussed by Meichenbaum[19] should be used to help increase the client's ability to label emotions, become more aware of body tension, and connect situations to negative emotions and relapse behaviors. Also useful is helping clients develop skills in meditation, thought stopping, and building a repertoire of sobriety scripts.[20] These techniques can increase clients' tolerance for withstanding strong emotions so they will not avoid negative affect or seek relief through mood altering substances. Importantly, these interventions are in a category of coping skills which can also promote ego strength, defined as the internalized capacity to manage emotional conflict.[21] Hence, they will not only increase clients' resistance to substance abuse relapse, but will also provide clients with inner strength to cope with trauma processing later in treatment.

Another important early intervention is educating clients about the symptoms and cycles of both disorders, their interplay, and differences in developing strategies to manage them. It is especially important to discuss PTSD symptoms and approach them as surmountable problems. This will help alter the meanings clients have attributed to their post-trauma symptoms, as well as provide material to explore issues such as (a) victimization vs. survivor status, (b) control vs. human limitation, and (c) situational influences vs. free will.[22]

Counselors must guide and encourage clients toward self-disclosure in order for the work of trauma processing to be productive. In PTSD/SA therapy, it is often helpful to first have clients talk about their addiction and the destructive behaviors it has generated. Second, queries should be made about childhood memories, family-of-origin issues, and relationships, without delving too deeply into related traumatic experiences. Finally, to help clients develop sufficient motivation to work through the fear of reexperiencing the trauma, it will be necessary for them to explore the costs and benefits of coping mechanisms and defenses, clarify how learning factors may have contributed to current problems, and examine the benefits of new coping skills and of interpersonal intimacy. The counselor can explain how defense mechanisms can be useful ways for persons to maintain psychological integrity and manage anxiety, but when used rigidly and without discrimination, they become obstacles to growth and well-being. Similarly, any coping mechanism which is used indiscriminately or out of context eventually becomes more costly than beneficial to psychological well-being.

Trauma Process Therapy

At some point, therapy must focus on processing traumatic material. Clients with PTSD/SA progress more rapidly when they feel in control of anxiety-arousing situations. Clients need to be in control of the content of self-disclosure, and the counselor can control its affective impact. **It is important to help the clients develop internal self-controls while arousing minimal anxiety. To achieve this, the counselor can take the following steps:** (1) **devise means of insuring mild exposure to trauma-related stimuli** (e.g., pictures, readings, videos), (2) **develop the initial exploration of material around a general discussion of PTSD symptoms, and** (3) **move the client toward discussion of pretrauma events and activities.** For example, the counselor may explore childhood emotional vulnerabilities, not to uncover traumatic material, but to help the client examine what attitudes, fears, and self-concept he or she had at the time of the traumatic event.

Once a relationship of trust and confidence has been established, the counselor can begin to encourage clients to talk about the trauma, confused feelings and horror associated with the memories. In time, it will be necessary for the counselor and client to delve into details of the event: names, sensory impressions (e.g., smells, tastes, visions, sounds), and affect. The client must understand that the purpose of this painful exercise is the management of the consequent symptoms.

After the traumatic material has been initially explored, the counselor should focus on conceptions of self that have been forged by the traumatic experiences. Basic assumptions about self, others, relationships, and the future will be clarified and appropriately challenged. Stories, metaphors, and other narratives can help to change the internal schema of self-other relationships. Community and emotional support systems can be incorporated into therapy at this time to build on emerging affinity skills and enhance the use of emotional support in times of high stress.

There a several specialized therapeutic interventions which can be used in trauma resolution therapy. Among them are Eye Movement Desensitization and Reprocessing (EMDR), **a therapeutic procedure that involves having the client quietly re-imagine the traumatic event while the counselor solicits a series of lateral eye movements and helps the client develop cognitive and emotional reframes for the painful memories.[23] Another is implosive therapy, in which a client is purposely flooded with anxiety producing memories of the trauma.** In this technique, the counselor first helps clients progress into a state of relaxation, then asks them to imagine and describe the worst parts of their experience in detail. The anxiety produced in the client by this process is deliberately allowed to rise until the emotional impact of the recalled images appears to diminish.[24,25] We do not advise using implosive therapy

Table 2
CASE STUDY

During a special session on nightmare resolution, Gary W. volunteered to process his traumatic dream. This nightmare occurred two or three times a week and was a recapitulation of a combat event. His squad was part way up a hill while under fire from Vietcong soldiers above them. Gary's good friend, B.B. was the radio operator and received orders to cut the communication wires and return to an encampment at the bottom of the hill. B.B. proceeded to obey these orders by cutting the wires and motioning the others to follow him down the hill. Although Gary thought they could better escape by running in a different direction, he did not want to abandon his friend and so followed B.B. The entire squad plunged through the jungle at breakneck speed in the pitch-black of night. Suddenly, B.B.'s head exploded from the impact of enemy machine gunfire; he collapsed in front of Gary, who found himself covered with the blood and brains of his friend. Shaking and in a tremulous voice, Gary said he "did not even stop to be sure B.B. was dead" but continued in a terrified run to the bottom of the hill and the safety of the reinforcement encampment.

Gary sobbed while describing this event. When asked what bothered him the most about his nightmare, he was able to identify his negative self-belief: "I was a coward because I ran instead of trying to help B.B." While processing details of the dream with group members, he discovered that the other thing that haunted him was that, although they searched for bodies the next day, they never found B.B. Gary had some unrealistic fears that his friend may have somehow lived, even though he was certain that B.B. had taken several direct hits to the head. This uncertainty prevailed even when he discovered his friend's name listed in the Vietnam Veterans Memorial Directory of Names.[29]

After the short dream exploration period, Gary was asked what he needed to do to accept his friend's death. He said that if he could see the body, he could move on. He was then asked to "extend his dream" and explain what had to happen for him to feel more at peace. Gary clearly stated that whatever he needed to visualize to bring him peace had to be based on the reality that B.B. was dead.

Gary then described his nightmare extension. In the added portion of the dream, he and the other squad members looked for B.B.'s body at daybreak and found him halfway up the hill, lying face down, with most of his head blown away. He saw himself kneeling down beside B.B. and saying many things he had never had a chance to say, such as, "You shouldn't have gone that way, you dumb shit. Why didn't you listen to me? I am so sorry I didn't stop and make sure you were dead. I was just so scared. I never stopped missing you. I think of you every day. I'm so glad we had the time we did together." Gary was asked how he would like to change his negative self-belief regarding this nightmare. He replied that he would like to remind himself that: "I really did care about B.B. There was nothing I could have done to save him. I was not a coward. I did the best I could under the circumstances."

Each night for the next three weeks, Gary was instructed to first visualize the dream as he usually had it, slowly and in great detail. Next, he was to visualize the new ending and see himself saying all the things he never had a chance to say to B.B. He also was instructed to repeat the positive self-beliefs to himself each night and then listen to a relaxation tape immediately before going to sleep. He complied fully with the protocol and began to have the "new dream" within a week's time. By the end of three weeks, he completely stopped having this nightmare and had not dreamed about this traumatic event at the three-month post-treatment assessment. The nightmare resolution procedure left him with a great sense of self-efficacy and helped him work through his previously unresolved grief. The group processing of this event gave the other clients the opportunity to assist in cognitive restructuring, practice emotional support, and help promote self-forgiveness.

techniques with clients who are in the early process of SA recovery, as this may exacerbate symptoms and increase the risk of relapse. **A different method which may be useful is systematic desensitization.**[26] This technique is similar to implosive techniques except anxiety levels are constantly checked and not allowed to reach above 50. A scale such as the Subjective Anxiety Scale (SAS) developed by Wolpe[27] is generally used to measure distress levels as clients get closer to describing the actual traumatic experience. **Rather than flooding the client with immediate trauma stimuli, the counselors ask clients to imagine scenes that move them progressively closer to the traumatic event.**

A technique for resolving traumatic nightmares has recently been developed by Donovan and Padin-Rivera[28] and can be implemented in a group therapy format. The above case study illustrates its use.

Group Therapy for the Treatment of Comorbid PTSD and SA

For clients with substance abuse, group treatment has been the preferred therapeutic environment. Individual treatment has meanwhile been the primary therapeutic mode for clients with PTSD. However, as the benefits of group interactions are becoming widely acknowledged,

new clinical protocols are being developed that shift the preferred treatment for combined PTSD/SA to group approaches.[12,13] **Among the advantages to group therapy is trauma affinity. This is the feeling among clients that they each share similar experiences and thus have a common psychological foundation from which to begin recovery.** This group interaction variable has been shown to be at least an indirect healing factor in PTSD.[30] Also, especially in addiction recovery, the necessity of a supportive environment is vital to maintaining new behaviors. In addition, it has been established that socially and emotionally supportive environments are associated with improved adjustment to stress.[31]

We have developed a model for using group therapy in an integrated PTSD/SA treatment program.[13] **The program consists of an initial 12 weeks of intensive treatment with three weekly group sessions designed to promote a drug-free lifestyle, reduce symptoms of PTSD, and facilitate the development of new coping behaviors. A maximum of 10 clients enter the program and remain together throughout. Members are required to attend group sessions, engage in an exercise program, attend weekly relaxation classes, and engage in weekly individual psychotherapy. Throughout the program, members submit to weekly urine tests to verify that they have not been using drugs or alcohol.**

The follow-up phase lasts six months and requires members to meet once a week. **Objectives in this phase include facilitating continued abstinence, managing PTSD symptoms, enhancing interpersonal relationships, and helping clients develop vocational and leisure time activities.** General strategies include nurturing a peer support process, providing group activities that reinforce and enhance new coping skills, and integrating insights concerning connections between substance abuse and trauma-related behavior. We have assessed the effectiveness of our program using clinical observation and self-report measures. A review of our evaluation criteria is presented in Appendix A.

The program equally emphasizes the interplay of PTSD and SA disorder behaviors and the altered view of world and self that each disorder inevitably engenders. For our intervention work, we draw on strategies from constructivist and dynamic paradigms,[21] cognitive-behavioral models,[32] systems theory, and social psychology. One of the first tasks in treatment is to explore and bring to awareness each person's coping style and defenses. We also clarify for our clients how childhood and family learning may have contributed to the behaviors associated with their current problems. As such, the trauma experience is only one aspect, albeit an important one, of the life experiences to be explored in treatment in order to develop an atmosphere for change and healing.

Group members can become the most potent intervention tool of a therapy program.[26,33] However, many clients do not know how to make use of or offer support. **Counselors must teach, model, and reinforce skills conducive to building supportive relationships while trying to generate an atmosphere of active participation, non-judgmental listening, empathic responding, and self-responsibility for emotional reactions.** The aspects of social bonding necessary to recovery and the healing process are also emphasized. These themes are evoked in lectures, readings, group process, and through supplemental activities outside of group. Appendix B provides a summary of these group cohesion and progress factors: commonality, support, commitment, active learning, feedback, and challenge.

These factors can be especially important during trauma process groups. In our treatment protocol, each client is required to spend time preparing for trauma processing by writing a detailed account of his war zone experiences. He is then given a three hour session devoted to "telling his story" (relating war zone trauma).

It is a primary assumption that clients with comorbid PTSD and SA are at a crossroads between the needs for social bonds and isolation, will and surrender, and pride and shame. **Our task is to create conditions that allow them to feel safe when deciding to change from social avoidance to engagement.** Within the first week, we begin to work through fears of reexperiencing the trauma. The process starts with mild exposure interventions and, through emotion-focused exercises, proceeds to more intense traumatic material. **Exposure intensification follows this pattern: intellectual discussions, exposure to stimuli related to the trauma, hearing the traumas of others, verbal self-disclosure, and, finally, exploring emotions surrounding the traumatic events.**

Interventions combine educational, skill building, and process components. Educational components fo-

Table 3
CASE STUDY

John D. began his session by relating, with very little emotion what happened to him when his unit was ambushed. After mentioning that a good friend, Mr. B, died during the firefight, he quickly tried to move to the description of other events. He was slowed down by questions from both counselors and fellow group members who sought details regarding how Mr. B died and what his importance was to John. The following types of questions were asked: How did he die? Did you see him get hit? Where was he wounded? What did you see when you looked at him? What do you think about when you recall his death? How long had you known him? What was he like?

These questions brought out the issue of survivor guilt and eventually promoted movement towards grief resolution. John explained that he had refused to take an assignment as a radio operator because he knew it was particularly dangerous. Mr. B later accepted the joB John was mad at this friend for taking the assignment, but also feared that Mr. B died because he had refused it.

During the time set aside for structured feedback from other group members, ideas for cognitive reframing were provided by fellow combat veterans. Feedback included: "John, it wasn't your fault he died. I never would be a radio man either. Things happen in firefights and no one can stop it. He was lucky to have someone who really cared about him like you did. I know what it feels like to lose a good friend. I know why you feel guilty. My friend walked point for me on one mission and died. I always felt like it should have been me.

John was asked what he would say to Mr. B if he walked in the door right now. At this point, John began to sob and express more of his emotions. As if talking to his lost friend, he said, "Why did you take that job? I told you it would get you killed. I really felt bad when you died—I really missed you. I know you will understand why I couldn't even stop and make sure you were dead. I'm glad you haven't suffered all these years like I have. I'm glad you weren't an invalid for years. You were a real hero in my book and you always will be."

After this, feedback provided an opportunity for group members to actively participate and respond emphatically. When asked to describe how he felt, John said he had never told anyone how guilty and sad he had been after Mr. B died, and affirmed that he felt as if a big weight had been lifted from his shoulders. John was asked to write a letter to Mr. B saying all the things he had related during the group session. He took the letter on the group trip to Washington, DC, and left it at "The Wall." During the trip, John pledged to stop punishing himself for having survived and to make changes in his life to honor the memory of his friend.

cus on helping clients enhance their understanding of PTSD, substance abuse, and their interconnections. Lectures, videos, and slide presentations help clients understand how both disorders have influenced their past choices, and to accept personal responsibility for their current behaviors.

Skill-building sessions are intended to increase self-efficacy and self-esteem. Strategies focus on managing emotions without recourse to substance abuse, enhancing interpersonal relationships, and decreasing feelings of alienation. To prevent relapse, sessions focus on problem solving, goal setting, anger management, relaxation techniques, and stimulus monitoring.

Process components facilitate the client's exploration of emotions surrounding trauma experiences. Trauma processing is preceded by group and individual sessions which promote ideas of self-understanding, self-acceptance, and forgiveness. These sessions prepare clients for the cathartic experience of narrating their individual traumas, and serve the dual purpose of decreasing their sense of alienation and increasing their ability to give and receive support.

An intervention we have devised called "a letter to your father" provides an example of process components. During the fourth week of treatment, each client writes a letter to his father. This assignment is carried out regardless of whether or not the father is alive. The letters are not sent. Rather, this exercise gives each client an opportunity to express emotional vulnerability and understand that childhood experiences may influence their behaviors or reactions. Often a client will be asked to write more than one letter if some other male figure greatly influenced his or her childhood experiences. In these letters, each group member is asked to write about things his father did that he is thankful for, things that made him angry or sad, things he resents or regrets, and ways he wishes his relationship with his father had been different. These letters are then read over the course of two group sessions. Group members have the opportunity to demonstrate empathic listening, provide emo-

Table 4
CASE STUDY

Ray M. wrote a letter to his biological father, who had been an abusive alcoholic. In the letter, he recounted specific incidents of abuse included being forced to smoke a whole cigar when he was five years old as a punishment, watching his father kill his pet kittens with a knife, being terrified at age seven when his father took him along on an armed robbery attempt, and having to stand helplessly by as his father beat his mother. The client's feelings regarding these events were affirmed by fellow group members who were shocked and appalled by what was described.

A few weeks later, Ray described his war zone traumatic experiences. His unit had engaged in a number of search and destroy missions in Vietnamese villages. Ray's commanding lieutenant instructed the soldiers to rape and then do "whatever else" they wanted with the women. Although most of the company complied, Ray refused. He was taunted by the lieutenant for his noncompliance and implications were made that he was homosexual. His rage continued to build towards this officer until during one session of humiliation in front of his peers, Ray grabbed his rifle and shoved the bayonet into the man's abdomen. He later feared that he may have attacked the officer because he "was really a coward and secretly hoped to have to leave the war" through such an act. Group members helped Ray explore and process his rage. He gained the insight that his rage at the moment of attack wasn't directed solely toward the lieutenant, but was also fueled by and directed toward his father. By connecting childhood events and war zone experiences, Ray began the process of self-forgiveness. He felt more compassion for himself and consequently became less judgmental of others.

tional support, and reinforce the benefits of expressing emotions.

The central goals of group therapy for comorbid PTSD and SA are the development of insight and confidence, the mastery of impulses and emotions, the importance of human relationships, and the creation of effective self-monitoring skills. Prime factors emphasized among clients in recovery are therapeutic alliances. Counselors should present themselves as facilitators as well as educators about addiction, PTSD, and the connection between the two. Even during lectures, group discussion is emphasized to encourage members to ask questions, review old beliefs, and engage in dialogue.

Tasks for Counselors in Group

In therapy, recovery is often more a function of the relationship established than of the resolution of the intrapersonal conflict.[34] The counselor is an ally who enables clients to exercise their power and responsibility. In trauma process therapy, the counselor must be capable of withstanding volatile mood swings, anger, horror stories, and acting out, without being afraid or overwhelmed. He or she must not view clients primarily as either perpetrators or victims. The counselor must also be aware of the difficulty of confronting his or her own vulnerability. The failure to do so often leads the counselor to look for some flaw in the client that has led to his or her current condition. In group process, the counselor should focus primarily on developing ways to enhance the clients' social capacities. The counselor should teach, model, and reinforce skills conducive to building supportive relationships; generate a group culture and atmosphere of engagement rather than avoidance; assist in the generation of self-awareness in relations with others; and encourage the self-confidence clients need to effectively solve problems and set goals.

Conclusion

In this lesson, we have reviewed PTSD and substance abuse treatment models and have endorsed a view that considers the simultaneous treatment of both disorders as the most effective and efficient course to follow. Central to our discussion was the need to examine PTSD/SA comorbidity symptoms as not only parallel, but interactive variables which can affect each other over the course of treatment. Treatment must begin with abstinence. However, a treatment plan needs to involve considerations of such factors as the symptoms and problems specific to both disorders, chronicity or long-term imperviousness of both, psychiatric stability, general level of social functioning, and readiness and motivation. Issues not discussed which may need consideration as therapy progresses are moderating variables such as social support, family, vocational needs, cognitive deficits, and other comorbid disorders, all of which may greatly impact on clients' ability to engage in and complete a treatment

program. Also, for the purposes of this lesson, we have not addressed, in-depth, other treatment considerations such as the possible benefits of pharmacologic treatment, especially antidepressants and sleep disorder medications.

Finally, much of the work accomplished thus far in the assessment and treatment of comorbid PTSD and SA has been with veterans of the Vietnam War generation. However, as the effects of traumatic experiences such as early childhood abuse, rape, industrial accidents, and natural disasters receive more attention, PTSD/SA comorbidity treatment issues with these populations will subsequently need more exploration.

We noted that there is scant empirical literature on PTSD and SA which addresses important comorbidity issues of symptom interactions or treatment selection. In our healthcare climate which stresses treatment efficacy, more outcome studies are needed that compare sequential and simultaneous approaches to treatment; contrast outcomes between group and individual formats; focus on intensity, length and timing of interventions; and explore effective approaches to aftercare.

Appendix A

Clinical Guidelines for Therapeutic Progress

A working assessment model was developed to guide both clinical work and the empirical investigation of efficacy and effectiveness. Care was taken to develop assessment tools and admission criteria that facilitated verification of treatment effects. Two of the primary instruments used for diagnosis and for symptom severity assessment were the Addiction Severity Index (ASI)[35] and the Counselor Administered PTSD Scale (CAPS).[36] These were supplemented by other scales that examined psychological, social, and physiological variables. Treatment outcome was then measured immediately at posttreatment and then at follow-up periods of 6 months and 1 year.

Although these instruments are helpful, the counselor must develop guidelines to measure progress during the process of therapy. For substance abuse, these guidelines are usually abstinence, or at the very least, an immediate attempt at recovery after a relapse.[37]

Appendix B

Group Cohesion and Progress Factors

Commonality: Affinity in group work helps clients understand that they are not alone in their situation, problems, and conflicts. Many persons come to treatment with pride or fear that they are the only ones who have certain unwanted or disturbing thoughts, impulses, and fantasies, and that they alone feel guilty about past actions. **In a group setting, members learn that other members in treatment share similar past experiences, thoughts, and feelings.**

Support: The group can serve the vital function of teaching and practicing the skills of emotional support. Group members learn how to give support to each other beginning in the first sessions. **One-on-one interviews with each other should be required during the first few weeks of treatment.** Each member begins a dialogue with other clients in the group who are at various stages of recovery from both PTSD and substance abuse.

Commitment: Facilitators use group interactions to convey the risks and rewards of keeping a commitment to their own personal growth and to that of others. Both commitments are considered equally important. **Clients who have comorbid PTSD and substance abuse generally experience hopelessness and low self-esteem.** Because they are focused on their past troubles, they may feel they have nothing of value to offer others. **However, in the group, members discover how important their support can be to others.**

Feedback: Emphasis is placed on shaping how feedback is given and received. Positive feedback is defined as a verbal communication that is intended to help another member know oneself and how he or she affects others. **Facilitators should teach and reiterate the communication of effective feedback.** It is stressed that feedback should be supportive and not an attack on or manipulation of another to increase one's own self-importance. This emphasis on feedback helps group members expand their self-awareness and enhance their sense of value to others.

Active Learning: Group members are challenged to confront negative behaviors and cognitions by using drawings, readings, dramatic stagings, and written exercises. Together, they explore the behaviors and schema learned in their respective families of origin and examine how these may have become obstacles in their lives. The difficulty of overcoming automatic responses, behaviors, and assumptions learned while growing up and after their traumatic experiences is acknowledged. However, the need to unlearn ingrained habits of thought and behavior in order to move toward a more productive, fulfilling life is paramount.

Challenge: Facilitators should encourage clients to challenge each other to examine self-defeating behaviors and thought processes. Clients are required to confront their addiction lifestyle and examine how it has destroyed self-worth, integrity, faith and hope. They must also confront their PTSD behaviors and emotions: the chronic anger and resentment, isolation, numbing, shame, loss of meaning, and self-worth. It is vital that they uncover and examine their methods of avoiding pain, anger, vulnerability, and grief. They must practice new relationship skills and learn to label and express long-suppressed emotions. The goal is to reduce the chances that they will return to substance use.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

25. Which one of the following is *not* a general principal common to PTSD and SA therapy?

A. Engage the client in new behaviors

B. Develop a therapeutic alliance that gives responsibility for change to the client

C. Move clients through the process of self-exploration, interpretation, and reframing of life experiences

D. Elicit family suport wherever possible

26. Which one of the following statements best describes the authors' position regarding integrated PTSD and SA treatment strategies?

A. Group therapy that provides supportive communication and confrontative challenges helps to motivate clients to move beyond their fear, shame, and ambivalence.

B. Counselors should focus on their client's weaknesses to begin to transmit the view that they are survivors, not merely victims.

C. If a counselor has not had a personal experience similar to the client, he or she should not dislcose that information.

D. It is important that counselors set high expectations with clients concerning self-control and the client's ability to succeed.

27. In the process of trauma process therapy, it is important to help the clients develop internal self-controls while arousing minimal anxiety. Which one of the following steps is *not* used?

A. Place post-trauma experiences into the matrix of life.

B. Move the client toward discussing pretrauma events and activities.

C. Develop the initial exploration of material around a general discussion of PTSD symptoms.

D. Devise means of ensuring mild exposure to trauma-related stimuli.

28. There are specialized therapeutic interventions which can be used in trauma resolution therapy. Which of the following is *not* a specialized therapeutic intervention?

A. EMDR

B. Systematic desentization

C. Covert response therapy

D. Implosive therapy

Directions in Rehabilitation Counseling

Volume 9 Lesson 8

Program Evaluation and Assessment of Outcomes in Rehabilitation Settings

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Introduction

Today's rehabilitation professional works in a climate of accountability[1,2] with increasing needs to produce meaningful outcome measures in an environment where service delivery and reimbursement methods are changing.[3] Rehabilitation professionals must demonstrate the effectiveness of their services to varied constituencies including clients, employers, reimbursement sources, and accrediting agencies. Rehabilitation systems focus on program evaluation in order to identify both problems and strengths, enhance services, and improve quality. Considering the potential benefits as well as the accountability demands, it is imperative for practicing rehabilitation professionals to have a working understanding and a skill base in the area of rehabilitation outcome assessment and evaluation.

Using outcomes to measure a rehabilitation program's effectiveness and quality reflects a shift in orientation from a service-based to an outcome-based model. In a service-based model (i.e., medical model), rehabilitation services are centered around the remediation of deficits and clients are discharged to existing settings and situations consistent with their status following rehabilitative service. In the service-based model, the process involves the following steps: (*a*) assess/diagnose, (*b*) treat, (*c*) wait for result, and (*d*) discharge.[4] In contrast, an outcome-based orientation focuses its efforts and services on reaching outcomes consistent with the pre-morbid status of the client prior to acquiring a disabling condition. The focus is on reducing or removing the handicapping constraints that prevent clients from reaching their desired life outcomes through the following steps: (*a*) assess/identify skill requirement for success in the discharge setting, (*b*) project outcome, (*c*) define barriers, (*d*) define resources available, and (*e*) manage for results.[5] Service-based rehabilitation sets discipline-specific goals and focuses intervention on reducing impairments that undermine skill; outcome-based evaluation sets functional goals based on the outcome result to be achieved and focuses intervention on the reacquisition of functional skills.

In order to understand the process of outcome assessment and to faciltitate an effective program evaluation system, it is important to address the following questions: (*a*) Why is program evaluation being done and what will be the benefit? (*b*) What are rehabilitation outcomes? (*c*) How can rehabilitation outcomes be evaluated? (*d*) How can outcome evaluation results be best utilized and disseminated?

Why Do Program Evaluation?

Rehabilitation is a process facilitated by a broad and varied array of professionals who provide services in settings ranging from acute care to long-term community living for individuals with various needs and goals. **Assessment of program effectiveness and outcomes is of interest for the purposes of marketing,[5-6] meeting accreditation requirements,[7-8] and measuring client satisfaction and quality of life.[9]** Rehabilitation programs may examine their results in order to gauge their services against some ideal or "gold standard" criterion (e.g., accreditation standards of excellence) or in comparison to other similar agencies (e.g., regional competitors for referrals). Independent of requests from outside sources is a rehabilitation program's internal impetus to evaluate their services and outcomes in order to continuously improve and assure quality services (i.e., evaluation for improvement).

What is a Rehabilitation Outcome?

The word outcome connotes the end result of a service or intervention. However, rehabilitation professionals actually are interested not only in outcomes, but also in the process by which outcomes are achieved and can be facilitated. Rehabilitation professionals also recognize that most outcomes are merely a snapshot of a client's functioning which may be modified in the future given additional services, accommodations, time, maturity, and skill acquisition. How an outcome is defined for one program may be the end result for that service delivery system (e.g., acute care setting) but only the beginning status for another rehabilitation service (e.g., community independent living center).

Given the complex nature of rehabilitation practice, no one application exists that is inclusive of how rehabilitation outcome will be defined. Rather, defining rehabilitation outcome requires examination of the assessment question. **Outcomes may be one of the following four types, each of which addresses different assessment questions: (*1*) clinical, (*2*) functional, (*3*) satisfaction, and (*4*) cost outcomes.[10]** Clinical outcomes examine the physical changes that have taken place for the client as the result of a particular therapy or intervention (e.g., changes in strength). Functional outcomes look more at what the client may now be able to do in activities of daily living as the result of a particular rehabilitation service. For example, if a client gains upper-body range of motion through physical therapy, it may result in the ability to dress independently. Satisfaction outcomes examine how the client feels about the service he or she has received. Cost outcomes generally indicate the unit costs of rehabilitation services.

Outcomes are defined and measured in a variety of ways depending on the objective and the setting. For the purpose of illustration, two examples will be discussed which utilize different outcome definitions and processes of assessment: measurement of health-related quality of life outcomes[11] and effectiveness of rehabilitation for independence in the home and community.[12] Each of these processes utilizes a different definition of outcome and each is assessed for different reasons.

Health-related quality of life (HRQL) **can be conceptualized as a subjective rating of the gap or disparity between an individual's expectations and his or her achievements** (i.e., perceived reality) **with respect to the four core domains of well-being: functional, emotional, physical, and social.[11] A critical consideration for using quality of life as an indicator of outcome is that a person's appraisal of his or her current functioning is likely to vary greatly over time, requiring a longitudinal comparison.** An individual's assessment of HRQL can be measured at multiple time intervals such as prior to treatment/intervention (to determine baseline information), during the intervention, at the conclusion of the intervention, and at one or more points during follow-up evaluation. Follow-up assessment of outcomes can provide critical information because it allows for time and emotional distance between

the intervention and the return to life and adaptation within the community. **Counselors should recognize that there are limits to using quality of life indices as outcome measures for an agency or program as a whole because there are a number of factors** (e.g., age, disease stage, disease/injury type and site) **which may influence how individuals perceive their quality of life regardless of the quality of the rehabilitation services which were provided.** Therefore, quality of life measures may be most useful to evaluate perceptions at the individual rather than the organization level. At the individual level, these HRQL measures can help clarify a particular client's expectations and goals. Then, the individual's perception of HRQL can be enhanced by modifying expectations to reflect more realistic, attainable goals and/or by better targeting services to match goals and expectancies.

Outcomes in community-based rehabilitation and long-term support programs can benefit from examining progress and outcomes from the client's perspective on his or her progress in meeting individual life goals (e.g. pursuing employment, living independently) **in addition to evaluating the program's success in meeting industry standards for its particular type of service** (e.g., accreditation standards for inpatient medical rehabilitation). Functional outcome models for community-based rehabilitation services are targeted at three primary areas—living arrangements, supports, and daily activity. Therefore, evaluation of home and community rehabilitation progress and outcome involves an analysis of activities related to those areas such as: (*a*) activities of daily living, (*b*) safety awareness, (*c*) domestic stability, (*d*) work/education pursuits, (*e*) leisure life activities, and (*f*) community access.[12] **The focus of services in community-based evaluation is on skill application** (e.g., crossing a street, cooking a meal in one's own kitchen) **rather than on skill acquisition** (e.g., building muscle strength and coordination to ambulate, practicing tasks with adaptive equipment in a therapy room). Just as multiple time periods were suggested for data collection on quality-of-life perceptions, measures of community living need to be monitored through several stages as various interventions are applied, practice has occurred, and/or environmental variables have been modified.

How Can Rehabilitation Outcomes Be Evaluated?

The methodology of how outcomes are evaluated and assessed can be as varied as the results each method generates. However, there are general principles and guidelines which exist that provide a theoretical and conceptual framework to approach this rehabilitation activity. As previously stated, choosing the type of outcome to examine is largely dependent on the application and the purpose for gathering of the information. **As such, two guiding principles for process of evaluating outcomes are to** (*a*) **make conceptual considerations regarding the purpose and use of outcome measurements**[13] **and** (*b*) **have awareness of your organization's structure and activities.**" In doing so, the purposes as well as the methods for evaluating outcomes can be refined and determined.

CONSIDERATIONS IN OUTCOME ASSESSMENT EVALUATION:

When conceptualizing the use of outcome evaluation measures in rehabilitation, Keith and Lipsey[13] outline three major considerations for rehabilitation professionals. First, there must be awareness of the range of potential outcomes for what is being evaluated, which includes accounting for unintended negative or positive effects. This consideration is based on a theoretical conceptualization of the potential outcomes with a particular type of treatment, service, or intervention. For example, what might be expected for the successful job placement of persons with mild mental retardation may be different than that expected for persons with mild traumatic brain injury. **A second consideration for utilizing outcome measures relates to choosing when to assess and the type of measure to use.** Keith and Lipsey[13] postulate that it is a mistake to assume the only important outcome will occur at the end point in the delivery of a rehabilitation service. The third important consideration when using rehabilitation outcomes is knowing what is meaningful as an outcome for the recipient of a rehabilitation service. A client-oriented perspective accounts for the context of quality of life and the client's priorities when receiving a rehabilitation service.

The recognition of multiple outcomes is critical because rehabilitation professionals frequently need

to clarify, for funding agencies or family members, the possibility of different expectations for what the client should be or can be achieving at different points in the rehabilitation process. Sound understanding of the expected rate and range of effects from a rehabilitation service as well as sensitivity to individual variables (e.g., influences of age, environment, cultural background, family support) will prevent premature or inaccurate assumptions of finality or the conclusion that "this is the best that things can be" when considerable improvement still may be possible. **Outcomes do not reflect "the end" or the halting of progress.** However, reported outcomes can reflect a status of functioning at a particular point in time (e.g., as a client completes a particular rehabilitation program or intervention).

Outcomes must have some level of practical significance and are commonly measured against a set criterion (e.g., completing a training program, maintaining competitive employment). One method for comparing outcome results with a set criterion is with the use of a national database.[10] National databases offer information that is standardized from results of rehabilitation facilities which offer a similar type of service across the country. Schunk[10] argues that the comparative value of a national database offers greater credibility for outcome results than if the results are only made on an internal basis. Three nationally known database systems include Focus On Therapeutic Outcomes (FOTO), Medirisk, Inc., and Uniform Data System for Medical Rehabilitation.[14] Hicks points out that as more demands are being made for proof of rehabilitative effectiveness, more database systems are emerging.

PROGRAM STRUCTURE AND GOALS:

In addition to conceptualizing the use of outcome measures, rehabilitation professionals can benefit from awareness of their organizations' functions and structures. Dobrzykowski[7] stresses that rehabilitation professionals need to be concise concerning several aspects of their organization when thinking about using outcome measurements to assess the effectiveness of a program: (*a*) the program's mission; (*b*) the primary population served; and (*c*) the outcome methodology.

First, it is important to know an organization's place within the health care or rehabilitation industry. Rehabilitation is a diverse field comprising a variety of interventions each providing a different type of service. For evaluation outcomes to be valid measures of performance, it is important to have the correct standard with which to compare. **To find an appropriate standard of comparison, rehabilitation professionals need be clear as to the type of service provided** (e.g., job placement, independent living) **and the work setting** (e.g., community, inpatient medical rehabilitation).

When utilizing outcome measures, a second area stressed by Dobrzykowski[7] is the prevalent diagnoses of the clients with whom an organization works. **This is important because many evaluation outcome tools have been validated for a particular client population.** Thus, applying an evaluation tool for a client population for which it was not intended may yield invalid results. For example, Harris[4] described an outcome evaluation measure designed specifically for persons with post-acute brain injury. Harris's model encompassed outcome categories specific to a brain injury population, including outcome categories for behavior, community living skills, community resources, family counseling, patient counseling, education (school), medical, peer group, personal living skills, substance abuse, and vocational status. These may not be appropriate assessment categories for other types of injury.

A third area to address when using outcome measures in rehabilitation is training rehabilitation staff to understand what outcome measurement methodologies are and how to use them. **It is essential that such training clearly explains to the staff what an outcome is[4] and why their organization should utilize outcome measurements to enhance quality.**[7] Other components of training programs should include information on the operational definitions of measures and the procedures for data collection.

In-service training and consultative resources are available from the product designers and marketers of commercial outcome measurement methodologies. National outcome database systems offer self-study manuals, videotapes, 800 numbers, newsletters, and professional training sessions.[14] Two national outcome database systems, the Uniform Data System for Medical Rehabilitation and Medirisk, Inc., require evidenced competency by their users.[7] Lux and associates[15] described

training available for users of the Rehabilitation Outcome Measurement-II (ROM-II). Users of the ROM-II take part in ROM Certification Training to develop skills in data collection and clinical outcomes reporting. Training offers both discipline specific and non-discipline specific curricula. Users of the Functional Independence Measure (FIM) are trained in its use through training videos, training workshops, or self-study.[16] Users of the instrument must pass an examination that tests knowledge of the FIM's item definitions and functional levels prior to submitting FIM data to its owner, Uniform Data System for Medical Rehabilitation, for scoring.

General Guidelines for Evaluation Design

When using outcomes to evaluate the effectiveness of a rehabilitation program or service, there are a variety of considerations to make regarding the evaluation design. These considerations are based on factors such as the rehabilitation setting, the discipline of the rehabilitation professional, and the service that the professional provides. **The complexity inherent in rehabilitation may suggest a lack of uniformity in terms of how to use outcomes to measure the effectiveness of a rehabilitation service or program.** However, when designing evaluation measures, general guidelines exist that apply to most entities in rehabilitation. The following structure, adopted from a model presented by Fink,[17] provides a clear and effective outline that explicates a step-by-step blueprint for rehabilitation professionals to follow when developing assessment tools for examining outcomes to indicate the effectiveness of their services and programs.

STEP 1—ASK QUESTIONS ABOUT THE PROGRAM:

Typical questions should include: What are the program's goals and objectives? Does the program target certain individuals or groups? What are the relationships between the costs of the program and the services delivered? Which features of the program are unique? What are the program's essential elements of service delivery? How does the program evaluate rehabilitation outcomes for the services it provides?

STEP 2—SET STANDARDS OF EFFECTIVENESS:

This refers to determining what type of outcomes show effectiveness. For example, if the objective is to improve the independent living skills and general health of individuals with physical disabilities living in the community, then possible standards of effectiveness could include: reports from the individuals receiving the services, their family members, and other support personnel that their independent functioning has improved; observations by the evaluator of improved health maintenance and independent living; and physical examinations by physicians that reveal evidence of a reduction in secondary complications such as pressure sores or infections.

STEP 3—DESIGN THE EVALUATION AND SELECT PARTICIPANTS:

When considering the design of the evaluation, the following questions need to be addressed: How many measurements should be made? How many persons, groups, or facilities need to be included? How should the participants in the evaluation be chosen? When should the measurements be made?

STEP 4—COLLECT DATA:

The tasks involved in collecting data include the following: identify the variables to measure; select, adapt, or create measures; demonstrate the reliability and validity of the measures; administer the measures; and score and interpret the results. Typical sources of evaluation data include: literature reviews, performance tests, self-administered questionnaires, achievement tests, physical examinations, direct observations, medical record reviews, and interviews.

STEP 5—ANALYZE THE DATA:

How one chooses to analyze the data is contingent upon two factors: the characteristics of the evaluation question and standards; and if the variables are expressed nominally (e.g., did or did not receive a flu shot), ordinally (e.g., ranking on independent skill measures that document the level of assistance needed to complete a task), or numerically (e.g., scores on an interval scale of physical functioning, such as the amount of weight that can be lifted).

STEP 6—REPORT THE RESULTS:

The report contains descriptions of a program's characteristics and statements regarding its merits. The report also includes the purposes of the evaluation, the evaluation methods, the results from the evaluation, implications of the results, and the action the program plans to take to address any concerns identified by the evaluation.

How Can Outcome Results Be Utilized by Rehabilitation Professionals?

Perhaps the most important element of evaluating outcomes is thinking about how the results can best be used by rehabilitation professionals for positive benefit. Schunk[10] argues that outcomes can be utilized by rehabilitation organizations for both internal and external purposes.

Internally, outcome results can help rehabilitation professionals determine if their services are effective and efficient. From this information, rehabilitation professionals can make adjustments in their practice approaches to strive toward the highest quality possible. Elliott-Burke and Pothast[18] provide an example of an internal use for outcome results in their examination of client satisfaction in an outpatient orthopedic setting. **These authors conclude that an understanding of client satisfaction can assist rehabilitation professionals in the following six ways:**

1. **Help clinicians to better understand the client's expectations and perceptions of the service.**
2. **Provide an important part of a system of outcomes measurement.**
3. **Predict an individual's willingness to return for services in the future.**
4. **Determine compliance with and understanding of a treatment program.**
5. **Offer data to be used in a continuous process improvement program.**
6. **Creating a service that is oriented toward meeting the basic expectations of clients.[18]**

Elliott-Burke and Pothast reported on a study which measured factors of satisfaction for 19,834 patients over a four-year period in outpatient orthopedic rehabilitation settings across twelve states. **The top five factors they identified as having an impact on satisfaction included: (*a*) explanation of treatment; (*b*) personalized attention; (*c*) number of different treating clinicians; (*d*) how informed the clinician is about the individual's case; and (*e*) the amount of client input in setting treatment goals.[18]**

Related to an internal function for utilizing outcome measures, Morrison[8] argues that outpatient rehabilitation outcomes could be used to help rehabilitation organizations determine the cost-effectiveness of their services. Data which determine the cost-effectiveness of outcomes include factors such as types of treatments, diagnoses, progress, discharge status, cost of treatment, length of treatment, and staffing requirements.

In addition to the internal purposes for utilization of outcome results, there are numerous external audiences that are also interested in a program's results. **Two primary areas in the external reporting of outcome results are meeting accreditation standards[7,19] and proving cost-efficiency to health care payers.[5,10,15]**

Two organizations for which many rehabilitation facilities are required to report levels of quality in order to maintain accreditation standing are the Commission on Accreditation of Rehabilitation Facilities (CARF) **and the Joint Commission on Accreditation of Healthcare Organizations** (JCAHO). **Furthermore, various governmental agencies at the local, state, and federal level which have funding and oversight responsibilities for rehabilitation activities require reporting of service quality data.** Today's health care payer network (e.g., insurance companies, HMOs, and other payers of rehabilitation services) now requires rehabilitation agencies to demonstrate that their services are cost-effective and efficient. Lux and associates[15] argue that historically, rehabilitation professionals were not as pressured to document effectiveness as they are now. Rather, funding agencies took at face value the statements of rehabilitation professionals that their services were needed and justified further support. However, in the current health care environment, which includes the rap-

idly growing appearance of managed care[20] and decreasing availability of health care dollars,[15] effectiveness has to be proven. One consequence of the current health care environment is that long-term delivery of services, which is frequently necessary in order to attain functional independence, is denied because short-term results are expected and there is less patience for the attainment of goals which may take more time.

Schunk[10] stresses that in the current environment of competition for funding of rehabilitation services, rehabilitation agencies must be involved in marketing their services. Specifically, each rehabilitation agency must be able to differentiate the effectiveness and cost-efficiency of its services from other agencies and effectively disseminate that information.

As mentioned earlier, several national database systems exist that provide a comparative element for rehabilitation organizations to use in program evaluation (e.g. Uniform Data System for Medical Rehabilitation). Carey[5] provides a detailed description of such a system in his overview of the Level of Rehabilitation Scale American Data System (LADS). The LADS outcome measurement instrument is designed to measure the effectiveness of inpatient care and includes separate regression equations for 21 impairment groups. These equations are designed to predict length of stay, total charges, and discharge status. The LADS instrument also includes a curvilinear relationship measure between functional status at admission and functional gain observed after rehabilitation services, specific to different impairment groups. The advantages of using the LADS instrument for marketing purposes is that in several domains, it shows the characteristics of a rehabilitation organization that clearly distinguishes its services from other organizations (e.g., Agency A's brain injury clientele made a 10% higher level of functional gains at the conclusion of service compared with other rehabilitation facilities providing similar services).

Conclusion

The collection of rehabilitation outcome data is a vital practice activity. Not only does it convey to rehabilitation professionals the effectiveness and quality of their own services, but it conveys this information to outside entities that are equally interested in the results. In order to be done correctly, program evaluation requires attention to a variety of managerial, administrative, and organizational factors. At times, it can be an arduous task until a system is devised. It is also important to recognize that program evaluation is not solely the responsibility of the administration in that every member of an agency's staff may be called upon to collect information to enhance and document services. Although the rehabilitation professional staff may collect data regarding client performance and services delivered, a secretary may collect data on timeliness and an administrator may gather cost data. However, without program evaluation outcome data, rehabilitation professionals are limited in terms of documenting their effectiveness. In the current health care and rehabilitation environment, this approach may lead to loss of referrals, loss of funding, and eventually the demise of a program.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

29. Which of the following statements is/are correct?

I. **Outcomes in community-based programs can benefit from examining progress based on the client's perspective on his or her progress in meeting individual life goals.**

II. **The focus of services in community-based evaluation is on skill acquisition.**

III. **Using quality of life as an indicator of outcome requires a longitudinal comparison because a client's appraisal of current functioning is likely to avry considerably over time.**

A. I and II

B. I and III

C. II and III

D. I, II, and III

30. According to Elliott-Burke and Pothast, which of the following is *not* a way that understanding client satisfaction can assist rehabilitation professionals in utilizing outcome results?

A. Creating a service that oriented toward meeting the basic expectations of clients.

B. Predicting a client's willingness to return for services.

C. Determining a client's compliance with and understanding of the treatment program.

D. Reducing the cost of services by eliminating those from which a client did not benefit.

31. Which of the following statements is *not* correct:

A. When collecting data, one must demonstrate the reliability and validity of the measures used.

B. The standards of effectiveness should be standardized so as to be appropriate to all clients regardless of injury type.

C. Choosing how to analyze the data is contingent on the characteristics of the questions and standards and how the variables are expressed.

D. When considering the design of an evaluation, it is important to decide how many measures will be made and how the participants should be chosen.

32. Which of the following is *not* a major consideration when conceptualizing the use of outcome evaluation measures, according to Keith and Lipsey:

A. Being aware of the range of potential outcomes, including accounting for unintended negative or positive effects.

B. Being aware of the range of the programs structure and activities.

C. Choosing when to assess outcomes; it is a mistake to assume that the only important outcome will occur at the end of the delivery of the service.

D. Knowing what is meaningful as an outcome for the recipient of the rehabilitation service.

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Directions in Rehabilitation Counseling

Volume 9 Lesson 9

Mood Disorders Following Traumatic Brain Injury

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Introduction

Associations between traumatic brain injury (TBI) and a variety of neuropsychiatric disorders have been reported in the medical literature for many years. Adolf Meyer[1] identified a number of disorders which he referred to as the "traumatic insanities" and proposed that, in some cases, there may be associations between these disorders and specific lesion locations. Lishman,[2] in his classical study on the Oxford collection of head injury records, analyzed potential etiological factors involved in the development of psychiatric disturbances following traumatic brain injury. These studies stressed the importance of biological variables such as the extent of brain damage, lesion location, and the presence of posttraumatic epilepsy in determining the type and duration of psychiatric disorder.

There have been relatively few studies that have examined the prevalence of mood disorders associated with TBI and their effect on outcome variables. Issues such as the prevalence of major depressive disorder following TBI, clinical variables that predict the development of major depression, the natural course of post-TBI major depression, and the influence of mood disorders on the longitudinal evolution of post-TBI physical and intellectual impairments, are largely unexplored and deserve further investigation. This lesson focuses on the prominent mood disorders often occurring after TBI, highlights diagnostic and symptomolgic issues unique to this patient population, and recommends treatment approaches where possible. To familiarize our readers with the epidemiology, neuropathology, and outcome of TBI, we have included an extensive review in Table 1. The lesson itself covers mood disorders following TBI.

The person with TBI may need rehabilitation counseling for a variety of reasons, ranging from vocational counseling to case management. The counselor faces unique challenges with this population, including determining whether a mood disorder coexists with the physical injury. This lesson reviews several studies pertaining to such comorbidity, highlights diagnostic indicators, and offers recommendations for treatment. Upon reading this lesson, rehabilitation

Table 1

TRAUMATIC BRAIN INJURY: EPIDEMIOLOGY, NEUROPATHOLOGY, AND OUTCOME

Epidemiology

In the United States, the annual incidence of traumatic brain injury can be conservatively estimated as 200 cases per 100,000 population.[3] This figure includes new cases of TBI leading either to immediate brain death or admission to a hospital. **Epidemiological data suggests that most of these injuries occur among adolescents and young adults, with a second peak occurring after age 65.4 Males have consistently been shown to suffer two to three times the frequency of brain injury as females.**[4] African-American males also have higher rates of traumatic brain injury than other groups, perhaps because of increased rates of firearm exposure and homicide.[5] Low socioeconomic status, which is independent of both race and ethnicity,[6] is another risk factor for TBI. **The single greatest risk factor for TBI, however, is substance abuse and dependence.** Close to one third of brain injury patients have a pre-existing substance abuse disorder before the trauma, and more than 50% are intoxicated at the time of the injury.[7] **Motor-vehicle related accidents, including pedestrians hit by vehicles, are the most frequent cause of injury, particularly in younger patients. Falls are the second most prevalent cause of head injury, particularly among older patients.**[3] Assault, sports, and recreation accidents are other leading causes of head injury.[4] **Approximately 80% of hospitalized brain injuries are considered mild, 10% are moderate, and 10% are severe.**[3,9] Since 1979, the death rate associated with traumatic brain injury has decreased from 24.6 per 100,000 population to 19.3 per 100,000 population per year. This is probably due to improved vehicle safety as well as improved trauma care.[8] **The incidence of new disabilities resulting from brain injury is approximately 33 per 100,000 population per year or 83,000 new disabled patients each year.**[3] Total costs for all head injuries occurring in 1985 were estimated to be $37.8 billion.

Neuropathology

Head injuries may be divided into *penetrating* or *closed* injuries depending upon the integrity of meningeal coverings following the trauma. **Missile wounds are the most frequent cause of penetrating brain injuries. They tend to produce discrete lesions and may be complicated by infection or hemorrhage. Closed head injuries represent the majority of head injuries. Diffuse brain damage is a prominent feature of their pathophysiology.** Brain damage may also be classified as *primary* or *secondary*. **Primary brain damage is produced largely by contact and inertial forces that occur at the time of injury.**[10] This may lead to either focal lesions, such as contusions, intracerebral or epidural hemorrhages, or diffuse injury, such as axonal damage or diffuse ischemia. **Secondary brain damage is produced by pathological processes that are initiated at the moment of injury but span a variable period following the traumatic episode. These include brain damage secondary to ischemia** (i.e., hypotension, hypoxia), **brain swelling, raised intracranial pressure, and infection.**[11] Finally, brain injuries may be classified as *focal* or *diffuse* according to the extent and location of neuropathological changes. **Neurochemical changes following TBI:** During the last decade, there has been intensive research on the complex neurochemical changes occurring after brain trauma in an effort to identify specific interventions to prevent diffuse neuronal death. For example, a blockade of pathologic excitation of basal forebrain nuclei and resulting acetylcholine release may prevent neuronal cell loss and resulting behavioral deficits.[12,13] Another example is the blockade of the ascending biogenic amine pathways. **Circulating levels of catecholamines have been shown to significantly correlate with TBI severity as measured by Glasgow Coma Scale scores.**[14] **Prevention of the neurotoxic effect of the excitatory amino acids glutamate and aspartate released by traumatic injury may be another therapeutic intervention.** Overactivity of excitatory amino acid neurotransmitter systems may play a role in neuronal damage through changes in the membrane conductance of sodium and calcium ions.[15] Prignatano hypothesized that post-TBI changes in adrenocorticotropic hormone and cortisol levels may mediate changes in mood.[16] **Corticotropin Releasing Hormone also is involved in adaptation to acute stress and may be responsible for certain features of anxiety and depressive disorders.**[17] The magnitude, regional distribution, and rela-

counselors should be able to recognize when a client with TBI requires a psychiatric referral, and also be equipped to manage the client's treatment needs in order to maximize positive rehabilitation outcomes.

Depressive Disorders Following TBI

BACKGROUND:

Mood and anxiety disorders appear to be frequent complications among persons with TBI. The presence of such neuropsychiatric disorders may play an important role in shaping long-term outcomes. As such, rehabilitation counselors must be prepared to recognize these disorders and their effects when working with clients with TBI. Dimken and Reitan[35] reported on the longitudinal evolution of emotional functions (measured using MMPI scores) in a consecutive series of 27 TBI patients followed during 18 months. **They concluded that emotional disturbances tend to decline over time following injury and that they are associated with the presence of greater neuropsychological impairment. On the other hand, Fordyce et al.[36] found significantly higher MMPI depression scores in the chronic stage of TBI**

tionship of the temporal course of these neurochemical changes to mood disorders remains largely unexplored and constitutes an interesting field for further investigation.

Outcome

The long-term outcome of TBI patients is related primarily to the severity of the brain injury. In addition, the type and location of intracranial lesion as well as the efficacy of acute medical and surgical treatments may have a significant impact on long-term recovery.[18–20] Outcome also is influenced by concurrent factors including age,[21] socioeconomic status, educational level, previous psychiatric disorders (e.g., history of alcohol and/or drug abuse, personality disorders), **and premorbid social functioning levels.[18]** The quality and extent of rehabilitation services and the availability of social and vocational support also play significant roles in TBI outcome. Of 746 severe head-injury patients studied in the National Institutes of Health Traumatic Coma Data Bank,[22] 243 patients (32.5%) died, 315 patients (42%) were either severely disabled or in a vegetative state, 138 (18%) had moderate disability, and the remaining 50 (7%) had a good recovery, as measured by the Glasgow Outcome Scale at the time of hospital discharge.[23] **The Glasgow has been widely used as a measure of the long-term outcome of TBI patients.[24] It consists of five levels of outcome:** (*a*) **death,** (*b*) **persistent vegetative state,** (*c*) **severe disability** (conscious but dependent in activities of daily living), (*d*) **moderate disability** (disabled but living independently), **and** (*e*) **good recovery** (mild neuropsychiatric sequelae but able to resume an otherwise normal life). Although crude, the scale is acknowledged for both its validity and high reproducibility. Rimel et al.[25] analyzed the outcome of 170 patients with moderate head injuries at 3 months following the injury. **According to the Glasgow Outcome Scale, 38% of moderate head injury patients made a good recovery, 49% were left with moderate disability, and 10% had severe disability. The mortality rate was 3%. Patients with moderate head injuries may show cognitive impairment following brain trauma.** Rimel et al. found that only 4% of patients with moderate head injury were asymptomatic at 3 months, 93% complained of headache, and 90% were having memory deficits.[25] They also found a high rate of attention and memory deficits among 424 patients with minor head injury.[26] Levin et al.[27] reported on a group of 50 mild and moderate head injury patients and correlated different neuropsychological measures obtained in-hospital and at 1- and 3-month follow-up evaluations with serial MRI findings. **The TBI group had significantly greater neuropsychological impairment than a control group. These cognitive deficits showed an impressive recovery during follow-up and were not consistently related to specific lesion locations.** MRI abnormalities were present at baseline in 40 (80%) of these patients and gradually resolved by 3 months.[27] Disabilities are more often results of deficits in cognition and personality than of motor or sensory neurological sequelae (e.g., hemiparesis).[28] **The full impact of TBI is most clearly demonstrated in social and vocational adjustment.** Many patients are unable to return to work or to resume academic activities. In addition, those who do return to work frequently have to take less demanding jobs with reduced responsibilities and lower compensation.[29] Ruff et al.[30] analyzed predictors of psychosocial outcome following severe head trauma. They reported that 18% of former workers had returned to gainful employment and 62% of former students had returned to school by 6 months follow-up. For those not back to work or school at 6 months, 31% of former workers and 66% of former students had returned by 12 months. **The three most significant predictors for returning to work or school were age, intact verbal abilities, and speed of information processing.** In their series of moderate head injury patients, Rimel et al.[25] reported that 69% of patients who had been gainfully employed before the injury were unemployed at 3-months follow-up. **The most significant predictor of unemployment was severity of brain injury** (e.g., length of coma or length of posttraumatic amnesia). **Behavioral changes associated with TBI may disrupt interpersonal relationships and pose a great burden on family members.[28]** During the first year after the injury, more than two thirds of relatives experienced moderate to severe degrees of burden as a consequence of the behavioral changes in their family member.[31] Five years after the injury, the percentage of relatives experiencing emotional stress increased to 90%.[29] Consistent with these findings, Livingston et al., reported that about a quarter of family primary caregivers were depressed at 6 and 12 months following TBI.[32]

(i.e., 6 months after the injurious event) **than in the more acute stages.**

The reported frequency of depressive disorders following TBI varies from 6% to 77%.[33–37] McKinlay et al.[38] reported indirect evidence of a depressed mood in about half of their patients at 3, 6, or 12 months following severe brain injury. Kinsella et al.[39] reported that in a series of 39 patients within two years of severe brain injury, 33% were classified as depressed and 26% as suffering from anxiety. Schoenhuber and Gentilini[40] found depressive symptoms in 39% of 103 patients with mild head injury interviewed at one year follow-up and concluded that these patients had an increased risk of developing depression compared to an appropriate control group. **More recently, Gualtieri estimated that the frequency of major depression in traumatic brain injured patients lies between 25% and 50%.[41]** The variability in the reported frequency of depressive disorders, particularly major depression, may be due to the lack of uniformity in the psychiatric diagnosis. Most of the studies had relied on rating scales or relative's reports rather than on structured interviews and established diagnostic criteria (e.g., the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-III-R],

which was the most recent edition when these studies were conducted).

MAJOR DEPRESSION:

We have studied the prevalence, duration, and clinical correlates of mood and anxiety disorders in a group of 66 patients admitted to the Shock Trauma Center of the Maryland Institute of Emergency Medical Services System with TBI.[42] The patients in our sample were mostly white males of lower socioeconomic classes in their thirties. The principal cause of brain injury was motor vehicle accidents. The majority of patients (68%) had moderate brain injuries, 11 patients (17%) had severe brain injuries, and 10 patients (15%) had mild head injuries. Almost a third of these patients (30%) had a history of substance abuse and 11 patients (17%) had a history of psychiatric disorders, excluding substance abuse. We obtained follow-up data on 58 of the 66 patients (88%) initially admitted. Furthermore, 52 patients (79%) completed 3 out of 4 evaluations. There were no significant differences between the follow-up (n=58) and the dropout (n=8) groups in background characteristics, initial psychiatric variables, severity of brain injury, or type and location of brain damage.

PREVALENCE AND DURATION:

During the acute stage of TBI (i.e., approximately one month after the injurious event), **17 out of 66 patients** (26%) **developed major depression and another 2 patients** (3%) **developed minor** (dysthymic) **depression.**[42] **The prevalence of major depression during the year following TBI remained stable at 25%, with some patients recovering from major depression and other patients developing delayed onset depressions.**[43] **Minor depression was diagnosed in another 8 patients during the course of the year.** Of the 17 acutely depressed patients, 7 patients (41%) also met DSM-III-R criteria for the presence of generalized anxiety disorder, while none of the 47 nondepressed patients met that criteria.[44] There were 11 patients who developed delayed onset major depression at some point during the follow-up period (i.e., 4 patients at 3 months, 4 patients at 6 months and 3 patients at 12 months after brain injury). **Thus, 28 out of the 58 patients** (47%), **for whom we have follow-up data met DSM-III-R criteria for major depression during the first year after the traumatic episode.**[45] Previous investigators have suggested that transient disorders may be associated with neurophysiological disturbances (e.g., neurochemical changes in the injured brain) whereas prolonged disorders may be reactive psychological responses to physical or cognitive impairment.[46-49]

In our series, patients who developed major depression during the acute stages of TBI had an estimated mean duration of depression of 4.7 months, with a minimum of 1.5 months and a maximum of 12 months. There were 7 patients who developed transient depressive syndromes of less than 3-months duration (i.e., approximately 6–8 weeks) and another 7 patients developed more prolonged depressive syndromes lasting 6 or more months. In addition, we identified 2 patients with recurrent depressions who had major depression in the hospital but were not depressed at the 3- or 6-month evaluation, only to become depressed again at 1-year follow-up.[43] Anxious depressions had a significantly longer duration than nonanxious depressions; anxious depressions had a mean duration of 7½ months while nonanxious depressions had a mean duration of 1½ months.[44] Delayed onset major depressions had an estimated mean duration of 4 months.[43]

In summary, major depression appears to have a natural course of about 4 to 5 months following TBI. Some persons with TBI develop transient depressive disorders of 6- to 8-weeks duration and others have depressions lasting up to a year.

DIAGNOSIS:

Therefore, it is important that the rehabilitation counselor be aware of the criteria for diagnoses of psychiatric disorders they may encounter in clients with TBI. If symptoms are apparent, it is necessary to refer a client to a psychiatrist for full evaluation and pharmacologic and/or psychotherapeutic treatment. Failure to do so can be disastrous for the client.

In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), depressive disorders associated with TBI are categorized as "Mood Disorder Due to a General Medical Condition" with subtypes "with major depressive-like episode" (if the full criteria for a major depressive episode are met) or "with

Table 2
PERCENTAGE OF 66 TRAUMATIC BRAIN INJURY PATIENTS WITH OR WITHOUT DEPRESSED MOOD PRESENTING WITH DSM-IV SYMPTOMS FOR MAJOR DEPRESSIVE DISORDER

DSM-IV Symptoms	Initial Evaluation		6-Month Follow-up		1-Year Follow-up	
	Depressed	Nondepressed	Depressed	Nondepressed	Depressed	Nondepressed
Depressed mood	100	0*	100	0*	100	0*
Loss of interest/anhedonia	11	6	25	10	45	3*
Weight loss/loss of appetite	37	11*	17	6	18	3
Weight gain/increased appetite	5	7	8	3	18	0
Insomnia	53	26	67	16*	50	6*
Hypersomnia	32	34	17	23	19	0
Psychomotor agitation	32	4*	8	11	20	4
Psychomotor retardation	11	9	8	7	20	0
Anergia	58	26*	50	13*	45	9*
Feelings of worthlessness	5	2	50	6*	55	0*
Guilt	37	11*	54	16*	18	0
Diminished ability to think or concentrate	84	60	58	23	55	6*
Suicidal ideation	16	0	24	0*	27	0*

*$P < .05$
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depressive features" (prominent depressed mood, but the full criteria for a major depressive episode are not met).

One of the basic issues in the diagnosis of post-TBI depression is the specificity of the symptoms on which these diagnostic criteria are based. For example, symptoms of major depression such as changes in sleep, appetite, or libido occur in clients with TBI as a consequence of brain injury or as a nonspecific consequence of an acute medical illness. Thus, symptoms included in the criteria used to diagnose depressive disorders could occur independently of an associated mood disturbance. Consequently, major depressive disorder could be systematically overdiagnosed. On the other hand, patients may deny the presence of a depressed mood as part of a general unawareness of deficits or a denial syndrome. This would result in the underdiagnosis of depression.

We examined the specificity of symptoms of depression following TBI.[30] Depressive symptoms were divided into "autonomic" (physiologic) and "psychological" subtypes using the distinctions proposed by Davidson and Turnbull.[31] Then we analyzed their frequency among patients who presented with a depressed mood (no other depressive symptoms were required) compared to those without a depressed mood. **We found that, among patients who acknowledged a depressed mood, the mean frequency of autonomic symptoms was 2.7** (SD=1.4) **and of psychological symptoms was 3.1** (SD=1.9). **This was more than 3 times higher than the frequency of autonomic** (0.8 [SD=0.8]) **and psychological** (0.9 [SD=0.9]) **symptoms in patients who denied having a depressed mood. The psychological symptoms that discriminated depressed from nondepressed patients, at both the initial evaluation and at 1-year follow-up, were symptoms related to changes in self-attitude** (e.g., feelings of hopelessness, suicidal ideation, self-deprecation, and lack of self-confidence).

The only autonomic symptom that was significantly associated with depression over the entire year was lack of energy (i.e., subjective anergia). **Autonomic symptoms such as decreased appetite and weight loss, initial insomnia, and diurnal mood variation** (with morning depression) **appeared to be significantly associated with depression only during the initial or 3-month evaluation, not at 1-year follow-up. On the other hand, loss of libido, early morning awakening, difficulty concentrating, and inefficient thinking distinguished depressed from nondepressed patients only after 6 months or 1 year had elapsed. Finally, increased appetite, weight gain, and hypersomnia did not discriminate between depressed and nondepressed**

groups at any time (Table 2). **Anxiety symptoms were significantly associated with depression during the first 6 months following closed head trauma.** However, their frequency at 1-year follow- up was not significantly different in patients with or without depressed mood. The fact that the symptoms specific to depression changed over the course of the first year following TBI suggests that the nature and mechanism of post-TBI depressions may change over time.

Emotional lability is another differential diagnosis of major depression. It is characterized by the presence of sudden and uncontrollable affective outbursts (e.g., crying or laughing), **which may or may not be congruent with the client's mood and which occur spontaneously or are triggered by minor stimuli.** It lacks the pervasive alteration of mood and the specific vegetative symptoms associated with a major depressive episode. **Emotional lability, however, may respond to treatment with antidepressants.**

Table 3
DEMOGRAPHIC DATA AND HISTORY OF PSYCHIATRIC DISORDERS IN 64 PATIENTS WITH ACUTE TRAUMATIC BRAIN INJURY FOR DEPRESSED AND NONDEPRESSED GROUPS

Variables	Major Depression (n=17)	Nondepressed (n=47)
Age (mean SD)	26.8 (5.8)	29.5 (10.7)
Sex (% male)	82.4	87.2
Race (% Afro-American)	29.4	23.4
Handedness (% left)	5.9	8.5
Education, in years (mean, SD)	12.4 (2.0)	12.3 (2.1)
Hollingshead socioeconomic status (% class IV or V)	75	72
Family history of psychiatric disorder (%)	47.0 (8/17)	48.9 (23/47)
Personal history of psychiatric disorder (%)*	70.6 (12/17)	37.0 (17/46)

*P < .05.
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The differential diagnosis of post-TBI major depression includes adjustment disorder with depressed mood, apathy, emotional lability, and posttraumatic stress disorder. Clients with adjustment disorders develop short-lived and relatively mild emotional disturbances within 3 months of a stressful life event. Although they have depressive symptoms, they do not meet DSM-IV criteria for major depression. Posttraumatic stress disorder is another differential diagnosis. It occurs following an unusually severe distressing event, and it is characterized by symptoms of re-experiencing the trauma ranging from transient flashbacks or vivid nightmares to severe dissociative states in which the client behaves as if he or she is actually living the traumatic event. In addition, he or she typically avoids all the circumstances related to the trauma and become withdrawn and emotionally blunted.

Finally, TBI clients may present with apathetic syndromes that interfere with the rehabilitation process.[52] In our experience, apathy is frequently associated with psychomotor retardation and emotional blunting. Some clients, however, also have a depressed mood. Although apathy is frequently associated with frontal lobe damage, the relationship between apathy and the type, extent, and location of traumatic brain injury has not been systematically studied.

Relationship to Background and Impairment Variables

In our series of patients with acute onset major depression (n=17), depressed and non-depressed patients (n=47) did not differ from each other with respect to demographic variables, type or severity of brain injury, family

history of a psychiatric disorder, or the degree of physical or cognitive impairment. **There was, however, a significantly greater frequency of previous personal history of psychiatric disorder** (including substance abuse) **in the major depressed group** (Table 3). **Patients with major depression also had significantly poorer premorbid social functioning** (as measured by initial SFE scores) **than the nondepressed group.**[42] In addition, cross-sectional analysis at 3-, 6- and 12-month follow-up evaluations showed that poor social functioning was the strongest clinical predictor of concomitant major depression.[43]

Biological Factors—The Importance of Lesion Location

There is some empirical evidence supporting an association between post-TBI depression and specific lesion locations.[33] **Lishman[2] reported that several years after penetrating brain injury, depressive symptoms were more common among patients with right hemisphere lesions. Depressive symptoms also were more frequent among patients with frontal and parietal lesions than among patients with other lesion locations.** Grafman et al.[34] also reported that several years following head injury, depressive symptoms were more frequently associated with penetrating injuries involving the right hemisphere (right orbitofrontal lesions) than with any other lesion location.

Of our 66 TBI patients, 42 (64%) had a diffuse pattern of brain injury on their CT scans and 24 (36%) presented with focal lesions. Among the 42 patients with diffuse injury, 11 (17% of total) had normal CT scans. Among the 24 patients with focal injury, the lesion was surgically evacuated in 12 patients (18% of total) and 9 of these 12 patients had an acute subdural hematoma, 2 patients had an epidural hematoma, 1 patient underwent a right temporal lobectomy and 6 patients also had associated parenchymal contusions. The remaining 12 patients (18%) had brain contusions greater than 25cc on their CT scans. In addition, 3 of these patients had associated small extraparenchymal hemorrhages (2 subdural and 1 epidural) that did not require surgery. **There were no significant differences between the patients with major depression and the nondepressed patients in terms of the frequency of diffuse or focal patterns of injury.** In addition, there were no significant differences between the groups in terms of the frequency of extraparenchymal hemorrhages, contusions, or intracerebral or intraventricular hemorrhages.

A logistic regression model that takes into account all of the sites of brain injury showed that major depression following acute traumatic brain injury was associated with the presence of left dorsolateral frontal and/or left basal ganglia lesions and, to a lesser extent, with right hemisphere and parieto-occipital lesions.[42] The association between left anterior lesions and major depression held up only during the initial evaluation, a finding that may be related to the fact that 5 out of 8 acutely depressed patients (62.5%) with left anterior lesions had transient depressive syndromes. These transient depressions were also associated with diffuse patterns of brain injury and left sub-cortical involvement.[43]

Delayed onset depressions were not related to the presence of specific lesion locations. **Rather, they were associated with a personal history of psychiatric disorder and with poor social functioning levels.**[45] Thus, psychosocial factors appear to be more important in the chronic stage of TBI.

In summary, some acute onset depressions appear to be related to lesion characteristics and may be due to the biological responses of the injured brain. Left dorsolateral frontal and left basal ganglia lesions were strongly associated with major depression during the initial in-hospital evaluation. These may be strategic lesion locations which elicit biochemical responses that ultimately lead to the clinical manifestation of depression. **By 3-months follow-up, however, the major correlates of depression were previous history of psychiatric disorder and impaired social functioning during the 2 weeks before assessment.** Thus, prolonged or delayed onset depressions may be mediated by psychosocial factors suggesting psychological reaction as a possible mechanism.

Secondary Mania

Secondary manic and hypomanic states have been reported in a number of organic disorders such as thy-

roid disease,[55] uremia,[56] vitamin B12 deficiency,[57] or following open-heart surgery.[58] Mania also has been associated with brain tumors,[59] central nervous system infection,[60] stroke,[61] and TBI.[62] Shukla et al. reported on 20 patients who developed manic syndromes after closed head trauma. **They found a significant association between mania and the presence of posttraumatic seizures, predominantly of the partial complex type** (temporal lobe epilepsy). **They also found no association with a family history of bipolar disorder among 85 first-degree relatives.[63]**

We have previously reported on 25 patients with manic syndromes secondary to cerebrovascular, traumatic, or neoplastic brain lesions. **We found that secondary manic patients had a significantly greater frequency of right hemisphere lesions, particularly in specific limbic-related areas such as basotemporal or orbitofrontal cortices, thalamus, or basal ganglia.[59,64] In addition, both genetic vulnerability and the presence of subcortical atrophy were identified as probable risks factors for the development of mania following brain injury.[65]** We have also studied the prevalence of manic syndromes among our sample of 66 TBI patients.[66] **There were 6 patients** (9%) **who developed secondary mania at some point during the follow-up period** (i.e., 5 patients at 3 months and 1 patient at 6 months after brain injury).

Although manic episodes lasted only approximately 2 months, the presence of an elevated or expansive mood had a mean duration of 5.7 months. Secondary mania was associated with the presence of temporal basopolar lesions. It was not related to the type or severity of brain injury, degree of physical or intellectual impairment, level of social functioning, or the presence of a family or personal history of psychiatric disorder. In addition, secondary mania was not associated with the development of posttraumatic epilepsy.

Effect of Mood Disorders on the Outcome of TBI Patients

We examined the factors which contributed to deterioration in social functioning, activities of daily living, or intellectual function during the first year after traumatic brain injury.[67] Change was estimated for each patient using a simple linear regression of time (months postinjury) on each of three impairment scales (MMSE, JHFI and SFE). The slope (B) was taken as the degree of change that individuals showed on that scale. Negative slopes for JHFI and SFE and a positive slope for MMSE reflected recovery. The poor outcome groups were defined by identifying those patients who had a deteriorating slope in the linear regression of time on SFE, JHFI or MMSE scores and fell outside the interquartile range (p75–p25). There were 11 patients (21%) who fulfilled these criteria for SFE, 7 (13%) for JHFI and 11 (21%) for MMSE. The rest of the patients (e.g., 52 2 11=41 for SFE) constituted the control groups.

Age, sex, education, socioeconomic status, premorbid levels of social functioning, previous personal history of psychiatric disorder, and previous history of substance abuse did not appear to be significant predictors of outcomes in terms of psychosocial or cognitive functioning or concerning the activities of daily living. **Logistic regression analysis identified race** (African-American) **as the only background variable significantly associated with a poor psychosocial outcome. Patients with a poor outcome in the recovery of activities of daily living had a significantly higher frequency of focal** (mass) **injuries when compared to the control group. Logistic regression analysis disclosed a significant association between the presence of right hemisphere lesions and a poor psychosocial outcome.**

At the time of the initial evaluation, 13 of 52 patients (25%) **with adequate follow-up data were diagnosed as having major depression.** One patient had minor depression and the remaining 38 patients (73%) were nondepressed. We assumed that an effect of depression on long-term outcome would only be identifiable in those depressive disorders with a longer course. Thus, patients with prolonged major depression (i.e., 6 or more months) constitute the major depression group. **There was a significant association between poor psychosocial outcome and the presence of major depression. Patients with short-term depression** (i.e., less than 3 months) **recovered like nondepressed patients.** Half of the patients with major depression and initial activities-of-daily-living impairment had poor outcomes and none of the nondepressed patients had a poor activities outcome.

Major depression appeared to have a deleterious effect on both psychosocial and activities-of-daily-living outcome. It is, therefore, imperative that mood disorders be detected and treated as early as possible. Of course, because such disorders may only begin to surface weeks after the initial trauma, the rehabilitation counselor is often in an ideal position to identify affective symptoms and make the appropriate psychiatric referral. When clients resist the notion of seeing a psychiatrist, the counselor's training in multicultural considerations can make the pivotal difference. Because depressive disorders have a mean duration of less than 6 months, we assume that depression may have negatively influenced patients' participation in rehabilitation efforts early during their early course of recovery.

They may not have recovered these early losses even when the depression was over.

Treatment of Mood Disorders

Patients with brain injury are more sensitive to the side effects of medications, especially psychotropics. Silver and Yudofsky proposed several general guidelines for their use in this population.[68] Doses of psychotropics must be prudently increased, minimizing side effects (i.e., start low, go slow). However, the patient must receive an adequate therapeutic trial with regard to dosage and duration of treatment. TBI patients must be frequently reassessed to determine changes in treatment schedules. Special care must be taken in monitoring drug interactions. Finally, if there is evidence of a partial response to a specific medication, augmentation therapy is warranted, after considering the mechanisms of action and side effects of the second drug.

To our knowledge, there have been no double blind, placebo controlled studies of the efficacy of pharmacologic treatments of depression in TBI patients. **Selection among competing antidepressants is usually guided by their side-effect profiles. Mild anticholinergic activity, minimal lowering of seizure threshold, and low sedative effects are the most important factors to be considered in the choice of an antidepressant drug in this population.[69] Tricyclic antidepressants have important anticholinergic effects that may interfere with cognitive and memory functions. In addition, they may lower the seizure threshold. If, however, a decision is made to administer tricyclics, nortriptyline** (Pamelor; starting at 10 mg/day) **constitutes a reasonable alternative, provided that blood levels and toxic effects are carefully monitored.[68] Selective serotonin-reuptake inhibitors have a less adverse side-effect profile.**[70] The most common side effects include headache, gastrointestinal complaints, insomnia, diminished libido, and sexual dysfunction. Fluoxetine (Prozac; starting at 10 mg/day), sertraline (Zoloft; starting at 25 mg/day), or paroxetine (Paxil; starting at 5– 10 mg/day) are among the most useful drugs in this group. **Trazodone** (Desyrel) **is an alternative antidepressant that also inhibits serotonin reuptake.** Treatment is started at low doses (50–100 mg) at bedtime, following a snack. The dose may be gradually increased every 3–4 days up to 400 mg. **The most troublesome side effects are sedation and orthostatic hypotension.**[71]

There are case reports of successful treatments of post-TBI depression with psychostimulants.[72] These include dextroamphetamine (Dexedrine; 8–60 mg/day), methylphenidate (Ritalin; 10–60 mg/day), and pemoline (Cylert; 50 to 75 mg/day). They are given twice a day with the last dose at least 6 hours before sleep, in order to prevent initial insomnia. Treatment is begun at lower doses and then gradually increased. Clients taking stimulants need close medical observation to prevent abuse or toxic effects. The most common side effects are anxiety, dysphoria, headaches, irritability, decreased appetite, insomnia, cardiovascular symptoms, dyskinesias, or even psychotic symptoms.[73]

Electroconvulsant therapy is not contraindicated in TBI patients and may be considered if other methods of treatment prove to be unsuccessful. ECT should be administered with the lowest possible effective energy, using pulsatile, nondominant, unilateral currents, with an interval of 2–5 days between treatments and 4 to 6 treatments for a complete course.[68]

Buspirone (BuSpar), **a drug that has an agonist effect on 5-HT1 receptors and an antagonist effect on D2 dopaminergic receptors, has proved to be a safe and efficacious anxiolytic.** Initial dosing is 15 mg a day given in three divided doses and it may gradually be increased (by 5 mg every 4 days) up to 60 mg a day. The most common side effects are dizziness and headaches.[74]

Finally, social intervention and adequate psychotherapeutic support are extremely important in the treatment of depression following traumatic brain injury.[74,75] There have been no systematic studies of the treatment of secondary mania. There are, however, several reports of potentially useful treatment modalities. Bakchine et al.[76] conducted a double blind, placebo controlled study, in a single patient with secondary mania following TBI by using a crossover design and comparing the number of manic symptoms associated with each treatment. **Clonidine** (Catapres; 600 mg/day) **was effective in reverting manic symptoms, carbamazepine** (Tegretol; 1,200 mg/ day) **did not elicit mood changes, and l-dopa/benserazide** (375 mg/day) **resulted in an increase of manic symptoms.**

Lithium,[65] carbamazepine,[77] and valproate[78] therapies have also been reported to be efficacious in individual cases. However, lithium has been reported to impair cognitive performance in traumatic brain injured patients.[79] In addition, it may lower the seizure threshold. Some psychiatrists limit its use to patients in whom bipolar disorder preceded the onset of TBI.[68] **The mood stabilizer and anticonvulsant carbamazepine should be gradually increased to obtain therapeutic blood levels** (8 to 12 mg/ml). **Complete blood counts should be obtained every 2 weeks for the first 2 months of therapy and every 3 months thereafter. Liver function tests also should be obtained every 3 months.** Frequent side effects include sedation, dry mouth, gastrointestinal upset, drowsiness, impaired concentration, ataxia, nystagmus, and rash. Severe complications include pancytopenia, aplastic anemia, and cholestatic jaundice. **Valproic acid** (Depakene) **may be progressively increased from 500 mg a day up to the dose necessary to obtain plasma levels between 50 and 100 mg/ml. The maximum recommended dose is 60 mg/ kg a day divided into 2 to 4 doses.** Valproic acid may have potentially serious side effects including hepatotoxicity, which ranges from a discrete elevation of transaminases and serum ammonia levels to irreversible liver failure. Hemorrhagic pancreatitis also has been reported. The most common side effects are drowsiness, tremor, gastritis, and weight gain. Liver function tests and serum amylase levels should be monitored.

Finally, pathological emotions may respond to treatment with antidepressants, such as amitriptyline[80] or fluoxetine.[81,82] There is, however, a great variability in treatment response among brain injury patients, with some showing a rapid response at relatively low doses and others requiring more time and higher doses. It is obvious from this discussion that controlled treatment trials of post-TBI mood disorders are desperately needed.

Summary

Traumatic brain injury represents one of the major public health problems in the United States. Trauma may produce either focal or diffuse brain injury resulting in death, permanent disability, or full recovery. Major depressive disorders occurred in about one quarter of our adults with moderate or severe head injury and usually lasted about 4–5 months. Major depression was associated with severity of social impairment, left anterior brain injury, and impaired social and physical recovery. Mania occurred in about one tenth of our patients during the first year following trauma and was related to the existence of basotemporal lesions. There are no controlled treatment trials of mood disorders following TBI. Further studies of the causes, consequences, and treatment of mood disorders following TBI are desperately needed.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

33. According to Lishman, depressive symptoms that occur several years after penetrating brain injury were more common among patients with lesions in all of the following locations *except*:

A. Right hemisphere

B. Left hemisphere

C. Frontal

D. Parietal

34. Which of the following statements is *not* correct?

A. A recent assessment of the incidence of major depression in traumatic brain injured patients lies between 25%–50%.

B. The only autonomic symptom significantly associated with depression in patients with TBI in the authors' study over the entire year following TBI was diurnal mood variation.

C. TBI patients with major depression exhibited greater frequency of previous psychiatric disorder and poorer premorbid social functioning.

D. In the authors' study, patients developing mania following TBI showed a significantly greater frequency of right hemispheric lesions, particularly in specific limbic-related areas.

35. Which of the following statements is correct?

A. Patients with brain injury are less sensitive to the side effects of medications, especially psychotropics.

B. Electroconvulsive treatments are contraindicated in TBI patients.

C. There are no drugs that can be effectively used to manage post-TBI manic reactions.

D. The use of tricyclic antidepressants to manage depression in TBI patients is associated with a risk of cognitive and memory dysfunction and may lower the seizure threshold.

36. Which of the following DSM-IV symptoms were greater in nondepressed than depressed TBI patients at the initial evaluation?

A. Psychological agitation

B. Anergia

C. Hypersomnia

D. Diminished ability to think or concentrate

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Directions in Rehabilitation Counseling

Volume 9 Lesson 10

Interventions With Autistic Clients And Their Families

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Introduction

Autistic disorder is a chronic neuropsychiatric disorder. Individuals with autism require assistance from caretakers and the utilization of numerous community resources over the course of a lifetime. Throughout development, critical assessments and interventions have a significant impact on whether or not autistic individuals realize their full potential. A description of early assessment and intervention techniques from infancy throughout childhood is beyond the scope of this lesson. Instead, this lesson focuses on providing information to rehabilitation counselors about autistic adolescents and adults in terms of: (*1*) phenomenology, etiology, and course; (*2*) cognitive strengths and weaknesses; (*3*) assessments; (*4*) family issues; and (*5*) intervention and treatment strategies. Special attention will be given to a variety of interventions and treatments. The utility of each of these methods depends on the age, level of functioning, and symptom profile of the autistic client, as well as family variables and available community resources. This lesson will guide rehabilitation counselors in the development and maintenance of interventions and treatment with autistic clients and their families. Familiarity with and integration of the phenomenology, etiology, and cognitive functions associated with autism will aid the rehabilitation counselor in deriving strategies for appropriate assessments and interventions. Working collaboratively with the family is crucial to this process.

Background

DEFINITION:

Autistic Disorder is a pervasive developmental disorder characterized by a dimensional triad which includes "markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests."[1] Delays or deficits in social interaction, and/or the use of language in social communication, and/or symbolic/imaginative play are evident prior to three years of age. Behaviors associated with each of these deficits are described in Table 1.

Other behavioral symptoms which may co-occur include aggression (toward self or others), hyperactivity, impulsivity, inattention, abnormalities in eating and sleeping patterns, hypersensitivity to certain sounds or touch, hyposensitivity to pain, and abnormalities in mood and affect.[1] It is unlikely that autism is a single neurological disorder. Thus, the symptoms, course and etiology associated with this disorder may vary from one affected individual to another.

Table 1
THREE DIMENSIONS OF AUTISTIC DISORDER

Impairment in Social Interaction
- lack of eye contact
- poor attachments
- aloofness
- lack of empathy/comfort-seeking

Disturbances in Speech and Communication
- mute or delayed speech
- monotonous or peculiar vocal intonation/ prosody
- echolalia (the involuntary repitition of a word or sentence just spoken by another person)
- lack of gestural communication
- deficits in pragmatic communication

Restricted Patterns of Behavior
- preoccupation with stereotyped interests/ activities
- rituals
- repetitive mannerisms
- extreme response to change in routine, environment and situations.

PREVALENCE:

Prevalence estimates of Autistic Disorder range from 2–5 cases per 10,000 individuals. Male to female ratios range from 2:12 to 4–5:1.1 Although this disorder occurs less frequently in females, the severity of mental retardation among females is usually higher. Prevalence estimates of epilepsy in autistic children range from 5% to 14% and 25% in adolescence and early adulthood.[2-5]

COURSE:

Autistic individuals live normal life spans. Particular symptoms may change or resolve during the course of their lives. For example, behavior problems and stereotyped movements are more prominent during childhood; the rate of seizures and psychological problems such as anxiety and depression increase as children grow into adolescence. As such, periodic reevaluation is important and changes in treatment may be appropriate. Approximately one-third of autistic adults have been found to demonstrate good outcome, achieving some degree of independence and self-sufficiency.[6-8] Although no clear data are currently available, the estimate for a good prognosis is now believed to be higher due to early detection and intervention. Two factors associated with outcome are overall intelligence and communicative speech at age five.[9] However, even among high-functioning autistic adults, significant deficits in social interaction remain.[10]

ETIOLOGY:

Although the development of autism was once thought to be solely associated with deficits in parenting, autism is now believed to be a familial,[11] heritable (concordance rates of 60% of monogyzotic and 0% of dizygotic twin pairs),[12] and genetically heterogeneous[13] disorder. Moreover, the interaction between environmental and genetic factors may compound the risk for development of this disorder (e.g. chemical exposure during pregnancy; untreated conditions such as phenylketonuria [PKU]).

Autism is a complex developmental disorder. Literature on the neuropathology of autism is vast and often contradictory. Although clinical manifestations of autism cluster into three core components, symptomatology varies among affected individuals. Moreover, there appears to be multiple underlying neuropathological mechanisms associated with autism. Treatment of autism requires appropriate delineation of each individual's behavioral and/or neurobiological profiles.

The most consistent neuropathological findings from post-mortem and brain imaging studies suggest that there are abnormalities within the hippocampus and amygdala;[14] anterior cingulate gyrus;[15] cerebellum;[14,16,17] brainstem;[17,18] and interactions between frontal/parietal lobes, neostriatum, and thalamus.[19] These abnormalities have been associated with deficits in socioemotional skills, processing of sensations and information, motor planning, and attention.

Neurochemical investigations of autism have been conducted to identify the underlying pathophysiology associated with its core components. Results from these studies have provided insight toward the development of new and effective pharmacologic treatments. Although serotonergic[20-23] and peptide[21,24-26] function have been most vigorously researched and implicated, other neurotransmitter function and peptide abnormalities also have been implicated. Serotonergic abnormalities are not specific to autism, and are often associated with many other psychiatric disorders. However, studies of the serotonergic system in autistic individuals are important because serotonin has been linked to repetitive and stereotyped behaviors, restricted interests, and rigidity, all of which are associated with autism. Opiate activity has been investigated in autism because behaviors associated with a dysregulated opiate system (i.e., self-injurious behavior, decreased pain sensitivity, stereotypies, attentional dysfunction, and social withdrawal) have also been associated with autism.

COGNITIVE FUNCTION:

Investigations of neuropsychological function in autism have yielded findings which are consistent with neurological abnormalities found in the brainstem, cerebellum, midbrain, and frontal lobe. The range of cognitive deficits associated with the neuropathology reflect the complexity of and the interactions among the neuroanatomical, neurophysiological, and neurochemical abnormalities which have been linked to this disorder.[27] Impairments in the following areas are associated with autistic disorder:

- General intellectual ability[28-30]
- Language capacities, especially verbal comprehension[31]
- Attentional set-shifting[32-33]
- Abstract problem-solving and cognitive flexibility[34]
- Socioemotional abilities[35]
- Visual memory[36]
- Motor planning[37]
- "Theory of mind"[38,39]

"Theory of mind" refers to the ability to recognize oneself and one's intentions as distinct from others and to comprehend the beliefs, feelings, and desires of others. Cognitive sparing of perceptual-motor function and rote memory have been demonstrated.[31,40-42] Many autistic individuals have exceptional mathematical, musical, and/or visuospatial skills.

Assessment

DIAGNOSTIC ASSESSMENTS:

Comprehensive diagnostic assessments of Autistic Disorder involve a psychiatric evaluation which includes a family history, a diagnosis based on the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)[1] **and the Autism Diagnostic Interview-R** (ADI-R).[42] **The ADI-R is a semi-structured psychiatric interview administered to the patient's primary caretaker or family member. A detailed physical examination including a neurodevelopmental exam may be useful.** Moreover, if warranted, a laboratory evaluation should be conducted to assess chromosomal (e.g., Fragile X syndrome), brain (e.g., structural/neurochemical), electroencephalographic (e.g., seizures), cerebral spinal fluid, sensory (e.g., visual and auditory), and metabolic (e.g., PKU) abnormalities.

COGNITIVE FUNCTION ASSESSMENTS:

Once the diagnosis has been determined, assessments of general intellectual and adaptive functioning and academic achievement are essential to identify whether specific learning disabilities or mental retardation exist. Further, tests of discrete neuropsychological func-

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Table 2
ACTIONS FOR FAMILIES OF AUTISTIC CLIENTS

- Finding out where/how to obtain appropriate treatment
- Increasing the understanding of behavior management
- Increasing sensitivity to nonaffected family members' feelings about the autistic child
- Reading informative books
- Selecting the most appropriate school or vocational environment
- Collaborating with professionals
- Increasing understanding/support from family, friends, and peers
- Learning how to deal with hope realistically
- Addressing time management problems
- Teaching/monitoring daily living skills
- Discussing whether to medicate
- Planning for the adult living environment as early as adolescence
- Conducting legal and financial planning
- Identifying and addressing emotional issues such as increased loneliness, especially during adolescence
- Addressing academic issues during adolescence; planning appropriate educational placement.
- Teaching the autistic individual to take reasonable risks
- Aiding in finding appropriate leisure pursuits or groups dedicated to specialized interests

tioning should be administered. Tests should be conducted to obtain a comprehensive assessment of cognitive strengths and weaknesses. Discrete neuropsychological functions include language, attention, executive (organization, planning, and categorization), learning and memory, visuospatial and sensory-perceptual, facial recognition/emotional labeling, sensory-motor skills, graphomotor, and motor functions. The Psychoeducational Profile (PEP-R)[43] and the Adult and Adolescent Psychoeducational Profile (AAPEP)[44] are used to assess specific characteristics of sociocognitive learning problems. Moreover, measures that examine comorbid disorders, such as anxiety and depression, should also be included in a comprehensive evaluation. **Once the overall diagnostic and neuropsychological profile has been determined, the rehabilitation counselor can begin working in partnership with the autistic individual and his or her family to develop an appropriate treatment plan.**

Family Issues

Families are faced with ongoing issues throughout the lifespan of the autistic child. Mothers of autistic individuals are usually the primary caretakers. As such, they are at greater risk of increased stress and depression than fathers are.[45] Table 2 is a summary of primary family issues presented by the mother of a high-functioning autistic daughter.[46] **The rehabilitation counselor must be aware of these concerns and assist the family in managing them.**

Interventions and Treatment

Although there is no known cure for autism, particular symptoms or maladaptive behaviors can be treated. Both pharmacologic and nonpharmacologic treatments and interventions have been available, but no single method has been deemed superior to others in all cases. **Generally speaking, treatment planning necessitates a multifaceted approach, taking into consideration the individual's age, diagnostic profile, level of functioning, treatment history, neurological status, need, and family/community resources.** Family issues affecting treatment planning include parental expectations, stress and depression in caregivers, marital status, and cultural background. Environmental variables focus on available school and community resources.[47] A comprehensive understanding of these factors along with a cooperative effort among the autistic individual, the family, and the rehabilitation counselor will create realistic, meaningful, and individualized treatment planning.

SOCIAL SKILLS TRAINING:

Theoretical Background of Social Deficits Affecting Social Skill Development

Impairment in social interaction is a major component of autism. Social impairments are pervasive, can be seen from a very early age, and often persist throughout the life span.[48,49] Individuals with autism often fail to engage in reciprocal social interaction.[50] They have difficulty initiating or sustaining social interaction

effectively. **Wing[51] described four types of autistic individuals based on social interaction.**

The first type is indifferent to others and does not seek or desire interaction. The second type accepts social interaction attempts made by others, but does not initiate social interaction him or herself. The third type desires social interaction but does not understand social rules. The fourth type is able to interact with others; he or she is often polite but interactions with others are rigid and mechanical. Individuals with autism may change subtypes as they grow older, or they may change depending on the situation.[51]

Autistic individuals often have difficulty with eye contact, including failure to reciprocate or exhibit it appropriately.[50] They often demonstrate stereotypical or self-stimulatory behavior. These behaviors often interfere with their ability to respond to the environment or to participate in social interactions. They experience a variety of language difficulties that also interfere with social interaction. Many do not develop language, or if they do, they often experience pragmatic language difficulties. Perseverative speech is often observed. Some individuals with autism recite scripts, repeating word for word the dialogue from movies, television shows, and conversations they have heard. Autistic children often use language to describe objects or to fulfill needs rather than for social purposes.[52]

Due to their rigidity and repetitiveness of thought and behavior, individuals with autism often have difficulty adapting their behaviors to changing social situations.[53] A social environment is fluid and requires flexibility. Social rules are often abstract and situation-specific in nature. **Individuals with autism are more comfortable with the object world because it is more concrete and stable.[50]**

When individuals with autism are taught verbal and non-verbal social skills, learning occurs in a mechanical and rigid manner rather than as an automatic part of development.[53,54] As a result, the learned skills often are not flexible, adaptable, or generalizable to a changing social environment or to novel situations.[53]

Autistic individuals have difficulty attributing beliefs and intentions to others ("theory of mind"). Without a "theory of mind," one has difficulty participating in social interaction due to the consequent difficulty of taking another person's perspective.[38] Autistic individuals have difficulty appreciating that others even have a point of view. This prevents them from understanding the listener's needs and using this feedback to modify their behavior. This can be seen when autistic individuals talk continuously about a limited range of special interests without consideration of the listener's lack of interest or understanding.[52]

Individuals with autism have also been found to have a poor understanding of non-verbal social cues including facial expression, body posture, and gestures.[56] For example, individuals with autism often use gestures to obtain things, but do not use them expressively, such as a touch on the shoulder to show sympathy.[53] **High-functioning autistic individuals tend to use their cognitive abilities to learn how to understand emotions, rather than automatically experience them.[54]** These problems are associated with a lack of empathy. They often have a short attention span and pay attention to the inanimate or physical aspects of the environment rather than to its social aspects. As a result, they have difficulty reading social information and cues and/or learning social skills.[57]

Autistic individuals often lack social opportunity. When autistic individuals are around others, they often spend more time alone and unoccupied compared to nonautistic individuals.[58] Their unusual behaviors and lack of social ability lead to difficulties with peers (e.g., teasing, rejection), further delaying social development.

Howlin identifies a variety of skills utilized by socially successful children.[50] They subtly enter peer groups by waiting, hovering, commenting on the groups activity, and moving closer to the group before entering. They do not make themselves the center of attention or cause disruptions. They use non-verbal behaviors effectively such as looks, smiles, gestures, and postures. They vary their social behaviors in response to situational changes. They take turns in conversation and try to be good listeners. They take the perspective of another person and consider both their own and the others' points of view. These are the skills that counselors must strive to teach to autistic children.

As individuals with autism become older they may desire social interaction, but they usually lack the necessary social skills. In their follow-up study, Rumsey et

al.[48] found that adults with autism often lacked independent friendships. Many had acquaintances through community health centers and religious groups, but they could not maintain these friendships outside of those settings. In addition, they were often teased or rejected by their peers due to odd or inappropriate behavior and the lack of social skills. **Psychiatric problems such as depression, anxiety, and obsessive or compulsive symptoms often develop as autistic individuals get older and may be related to increased insight into their difficulties.**[48,49,51]

Theoretical Background of Social Skills Training

Social skills training is based on social learning theory which assumes that many responses and behaviors found in individuals are gained from observations and reinforcement from others.[59] Mesibov[60] developed one of the first social skills programs for adolescents and young adults with autism. The goals of Mesibov's program include starting and sustaining peer relationships; the experience of positive social interactions; and the enhancement of self-esteem. The program targets the development of communication, problem-solving, and listening skills as well as the development of emotional understanding and recognition.

When developing social skills programs, it is important to remember that individuals with autism often lack an intrinsic interest in social interaction. To help motivate participation and promote social interaction, activities must be based on the participants' interests and skills.[52,60]

Specific techniques that can be used in social skills training include modeling, coaching, and role playing. These techniques should be used in environments that are as natural as possible to promote generalization of skills learned in social skills training.[52] Coaching autistic individuals as they interact with others can be utilized as a training technique by focusing on what's happening at the moment and discussing what the individual is doing. The coach can also interpret, reflect, and mirror ongoing events and the feelings of both the individual and the others involved to help promote perspective taking.[56] Dramatic modeling can be used to emphasize points and make subtle elements of social interaction explicit.[56] Role-play can also be used to teach and practice social skills by identifying, explaining, and then practicing with feedback.[60] During role-play, individuals can develop skills and scripts for commonly-faced social situations. This helps make the situations less anxiety-provoking and gives individuals a repertoire for interaction. It can also be used to help individuals learn to label, model, and talk about emotions. Role playing can be used prior to community trips to practice situations they may face.[61] Other skills that can be taught during role-play include reciprocal interaction, staying on a topic, asking questions, and following-up in response to what another person is saying.[60]

Videotapes of actors demonstrating appropriate social skills can be used to help autistic individuals observe and evaluate social behaviors.[52] A videotape of an autistic participant's social interaction can be used to illustrate how his or her behavior effects others and to identify the appropriate and inappropriate use of social skills.

Teaching social rules to be used in a variety of social situations is helpful in making the abstract social world more concrete and comprehensible to autistic individuals. Social rules should be generated; an example is a greeting rule, which would state that when meeting new people, one should look at them, smile, and say hello. Conversational rules such as taking turns, looking at the person you are talking to, and asking questions, may also be taught.[62]

Opportunities to utilize social skills must also be provided. Group trips to restaurants, stores, and sporting events provide social opportunities. Field trips also provide opportunities to practice skills learned in group in more natural and realistic settings. **These outings provide generalization of skills learned in the group setting, and these shared experiences provide topics for social conversations among group members.**[62]

Teaching leisure activities, including sports and games, is also important when working with autistic individuals. Leisure skills provide individuals with ways to interact with others and opportunities to feel success and acceptance.[61] Mesibov [62] suggests modifying the rules of games in an attempt to make them more socially interactive and more rewarding for individuals with autism.

Use of nonaffected peers in social skills groups is also important. These peers can serve as role models

of appropriate social behavior.[62] They should be provided with training that includes information about autism and about situations they may face when working with autistic individuals. Peers should also be provided with opportunities to express their thoughts and concerns about their experiences with the autistic individuals.[63] This forum will make the experience more successful and enjoyable for both the peer and the autistic individual.

The role of the group leader or the parent in social skills training is to facilitate interaction among the autistic individuals in the group rather than to direct behavior. He or she should make behavioral adjustments to suit the needs of the individuals with autism in order to help promote language use and interaction. This may require waiting long enough for individuals to provide answers and adjusting sentence length.[52]

Another useful technique suggested by Mesibov[60] includes incorporating a snack time into the group. This is a less-structured activity during which conversation and attention skills can be encouraged.

Henning and Dalrymple[61] also suggest educating individuals in the community who have regular contact with autistic individuals about the disorder and the behaviors they may encounter. These community members should also be given a contact person such as a parent or worker from whom they can request information or help.

Social skills must be addressed to help autistic individuals gain more success in the world they face. Impairment in social interaction is the one core component of autism that does not resolve across the lifespan. **Since social interaction is intricately tied into every aspect of rehabilitation efforts, counselors must attend to this primary issue. Social skills development will enhance every aspect of treatment planning.** Families must work collaboratively with counselors to reinforce and help generalize skills learned in the social skill training groups.

BEHAVIORAL TREATMENT:

Behavioral therapy has been an effective therapeutic modality in treating autistic clients.[6,63] Behavioral treatment targets specific behaviors and accentuates the immediate environment rather than etiological or historical factors. A detailed analysis of the functional relationship between the autistic individual and his or her environment is primary. Subsequently, individualized treatment planning can be developed to strengthen adaptive behaviors (via reward system) and/or to eliminate maladaptive behaviors (via time-out, punishment).[64] **Self-management treatment programs encourage independence and promote generalization of treatment to novel settings. This intensive behavior therapy model requires a collaborative effort among therapists, parents, and teachers.**[65,66] Limitations of this model include the length of time involved in treatment; methodological problems; and limited success with individuals who are older or mentally retarded.[67-70]

EDUCATIONAL TRAINING:

Highly structured, skill-oriented, and individually-tailored programs are the most effective training programs for autistic individuals. Schopler et al. [71] describe the Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH) system that has been developed as a structured training program for autistic children, but is also adaptable for adolescents and adults. **According to the TEACCH program, two important principles of the training include (*1*) improving adaptation, and (*2*) providing structured teaching at home, school, or work that is adjusted to the client's developmental stage.**

The first principle can be achieved by (*1*) skill development and enhancement through the integration of special interests, and (*2*) modifying or structuring the environment to accommodate the deficits. Diagnostic and cognitive assessments are needed to identify neurocognitive and psychosocial strengths and weaknesses. In adolescents and adults, the evaluation helps to identify educational needs for vocational placement and living arrangements.[44] Informal assessments by family members, teachers, and others closely associated with the autistic individual provide additional useful information. These combined processes aid in the analysis and development of environmental restructuring.

The second principle may be attained by providing structured teaching according to one's assessed relative strengths and limitations. This type of training provides

the framework in which living, social, and vocational skills are taught. **The overall goal is to maximize independent functioning. The four major components of structured teaching are: (*1*) physical organization, (*2*) schedules, (*3*) work systems, and (*4*) task organization.**[71]

Physical organization **aids autistic individuals' comprehension and capacity for maneuvering in their environments.** A visually organized area with clear borders for selected activities is useful, aiding in the identification of various activities and the relationships between them. Developmental and individual considerations need to be taken into account when defining the physical organization of space. ***Schedules*** **provide an adjunct to the physical structure, aiding in difficulties with time and sequence of events.** Visually clear schedules minimize attention and memory deficits, minimize temporal and organizational difficulties, compensate for receptive language problems, cultivate independence, and maximize self-motivation. ***Work systems*** **further enhance independence. These individualized work systems describe what activity/task one is supposed to do, how much work is to be done, and the goal of the activity/task when it is finished.** Again, developmental and individual considerations need to be taken into account. ***Task organization*** **provides instruction or 'blueprints' which clarify activity guidelines such as task requirements, sequences, and relevant concepts.** Instructions designed to accommodate both developmental level and individual needs provide a mechanism for teaching an autistic client to actively participate in the learning process. The individual incorporates new instructions instead of proceeding in a predetermined manner. In addition to the four major components of structured teaching, verbal and nonverbal directions, prompts (especially when teaching new tasks), and reinforcers are employed to enhance comprehension, adaptation, and motivation.

VOCATIONAL REHABILITATION:

Successful vocational placement of autistic adults depends on one's capacity for independent functioning and behavioral control in novel settings. Learning patterns, collaborative relationships, and structured training play important roles in the transition from school to work. The TEACCH approach offers a clear structure for rehabilitation efforts with autistic individuals.[72]

The TEACCH approach to vocational rehabilitation is a four-fold model, including: (*1*) collaborative efforts of parents and professionals; (*2*) a holistic approach to treatment; (*3*) assessment-based individualized treatment planning; and (*4*) a two-prong treatment approach: (*a*) skill and adaptive behavior improvement, and (*b*) environmental adaptation to accommodate deficit areas.

Collaborative efforts involve families working with rehabilitation counselors and other relevant professionals in a mutually supportive manner. Collaboration permits the exchange of information about the client, autism, and appropriate treatment strategies. Taking a holistic approach toward rehabilitation provides the autistic individual and his or her family with a greater likelihood of success. Regardless of the focus of the specific rehabilitation efforts, greater awareness of the individual's overall situation in the other areas of his or her life (e.g., living or school situation) will further enhance the effectiveness of the rehabilitation efforts. Assessment-based, individualized treatment planning provides a means of identifying one's interests and absolute/relative strengths and weaknesses. These findings can be integrated into the overall rehabilitation plan. The Adult and Adolescent Psychoeducational Profile[73] is an assessment tool specifically designed to evaluate independent functioning, vocational skills/behaviors, leisure skills, functional communication, and interpersonal interactions in autistic adolescents and adults.[44] It is based on direct observation and informant interviews (e.g., family, teachers, employers). If the rehabilitation focus is vocational placement, formal assessment (AAPEP) as well as a job analysis/functional assessment of the autistic client's actual performance and behavior specific to that job are essential. The two-prong treatment approach, which includes skill and adaptive behavior enhancement as well as compensatory environmental engineering, will increase the capacity for independent living.

As part of Title VII(c) of the Rehabilitation Act Amendments of 1986, supported employment (minimum 20 hours/week in local business/industry) **is available to individuals with severe disabilities.**[73] **This model requires support, training, and assistance to**

sustain vocational placement in actual work settings.[74] Van Bourgondien and Woods[72] describe four supported employment models available to autistic individuals: job coach; enclave; mobile crew; and entrepreneurial models.[75]

The *job coach's* responsibility includes teaching work readiness skills (e.g., time management, cooperation), locating the job, conducting a job analysis, and teaching essential job skills. **Autistic individuals do well in jobs that are repetitive and socially restricted.** This type of setting is often perceived as less than desirable to most others. Finding the right fit between an autistic individual's strengths and preferences and a job which appreciates these qualities provides an employer with a low turnover rate. Clerk, food-service, animal care technician, packing, and custodial positions are commonly sought for high-functioning autistic individuals. It is important that the job coach, caregivers, direct supervisor, and employer work together, especially during the initial period of training.

The enclave model requires a full-time job coach working closely with a group of autistic individuals (maximum of eight) **in a job placement, paid either by the employer or a nonprofit placement agency.** The group is responsible for either a specific task or an entire area of a job. Examples of enclaves include cafeteria or assembly work.[73] Benefits to a potential employer include a reliable and steady workforce and tax credit. Autistic patients who need more structure and supervision often succeed in this model.

The mobile crew model involves a small group of autistic individuals with a supervisor who rotate from one service job to another. **The types of jobs usually secured for this model include housekeeping, janitorial work, yard work, and landscaping. Individuals often specialize in particular work areas, based on their interests and skills. This model is often used as a transition from sheltered workshops to other types of supported employment.**

The entrepreneurial model integrates a group of 8–10 autistic and nonautistic individuals in the development of a business.[76] Printing, baking, or electronics are the types of businesses generally established. This model is especially tailored for the individual who needs further behavioral and production training.[75]

Supportive employment and other types of vocational training and placement (e.g. sheltered workshops) [77,78] also provide opportunities for social and recreational development. Autistic clients interact with others and may improve their social skills. Frequently, these vocational training settings are the only resource for socialization apart from home-based social oppurtunities. Simultaneous participation in social skills training groups may provide a means of practicing, reinforcing, and generalizing new social skills in a ereiprocal manner.

COUNSELING AND THERAPY:

Family-Centered Therapy

Early theoretical conceptualizations suggested that autism developed as a result of unconscious hostility and rejection by the parents.[79] More recently, a growing body of evidence suggests a neurobiological basis for the disorder. **The focus of treatment is no longer to separate autistic individuals from their parents and place them in alternative residential situations.[80] Rather, the focus is on collaborative work between parents and professionals in order to better understand and help autistic clients.[81,82]**

Collaboration between the family of an autistic individual and a rehabilitation counselor creates an environment in which (*1*) families are engaged in the therapeutic millieu; (*2*) a thorough understanding of the history and the role of the client within the family system is obtained; (*3*) families increase their awareness, use, and advocacy of community resources; and (*4*) families are educated to make informed decisions regarding treatment.[83]

When working within a collaborative framework, it is important to keep the individual characteristics of the family in focus. Interventions must consider the impact on each family member and on the relationships between them. Counselors must be aware of family members' capacity to form or leave relationships and must be aware of the family's ability to cope with stress and change. They must also be aware of the family's belief system in relation to cultural, ethnic, and religious views. Communication within and outside the family system must also be taken into consideration.

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The focus of therapy has shifted from psychodynamic to cognitive, linguistic, and social processes and interventions due to the growing body of evidence suggesting neurobiological bases of autism. Nevertheless, either direct or indirect expression of a range of feelings (e.g., anxiety, fear, anger, disappointment) especially in autistic adolescents and adults, has fostered the need to better attend to the emotional experience and development of these individuals. **Furthermore, support groups for the families of autistic clients are crucial. The physical, emotional, and familial stress of raising an autistic family member can put them at risk for a variety of psychosocial problems.**

Individual Therapy

Autistic clients often present with comorbid psychiatric conditions, frequently worsening during adolescence. These co-occurring conditions may be associated with insight about their social impairment and the fact that more is expected of them by others. Depression and anxiety are most commonly observed.[51] Psychiatric illnesses may be more easily recognizable in those who have enough language to express their concerns and symptoms. Therefore, it is important to carefully monitor autistic clients who have poor communication skills.

"One-to-one counseling relationships can provide autistic people with the structure, guidance, information, and support that they need to function more effectively in society. These relationships can help develop skills and guide the necessary environmental adjustments. Those working individually with high-functioning autistic adolescents and adults must learn about their clients' perspectives of the world, establish trust and develop rapport. One-to-one counseling sessions can achieve these vital objectives and then confront common issues of daily living."[51] Further, helping them to analyze and organize their thinking will aid in their comprehension of the environment, helping them find their place in and make sense of the world. **It is critical to help the autistic client analyze detail in conjunction with analyzing the context in which it exists. This process is especially difficult in situations with an emotional emphasis.**

The explanation of cause and effect relationships, especially in relation to one's own behavior, is an important component of counseling. Clients benefit from specific feedback about these relationships.

Lastly, coping with everyday problems, such as behavior management issues, is critically linked to overall adaptive functioning. It may be helpful to give concrete examples of why certain inappropriate behaviors (e.g., temper outbursts, interrupting others, excessive talking) may occur, and to discuss how everyday situations can be handled differently.

Group Therapy

Modifications of traditional group therapies have been employed with psychosocially impaired adolescents.[85,86] **Among autistic adolescents, a modified group therapy process is characterized by a structured group task that has a beginning, middle, and end; direct language; and nonverbal components such as movement, art, and music.[87]** Anxiety may be reduced by maintaining an orderly and predictable external environment in an otherwise chaotic world.[88] Additionally, multiple group leaders provide feedback and reinforcement for the direction of an intensive group intervention. A case study illustrates that this type of group process results in increased verbalization, the expression of feelings, and a heightened enthusiasm to participate.[87]

Communication Therapy

Although language and communication deficits may be viewed as a part of larger social problems, maximizing communication at any developmental level helps generalize treatment gains across settings. **Thought to be controversial and not yet critically assessed,[89,91] facilitated communication is a technique for nonverbal or expressive language-impaired individuals that has shown some success with autistic clients.[92]** Physical assistance is administered to an autistic individual with the goal of facilitating communication via a keyboard on a computer.

Residential Treatment

Residential treatment programs offer different levels of independent and community living.[93] The types of facilities include respite programs, group homes, supervised apartments, rural farms and residential institutions. Ac-

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Table 3

SUMMARY OF PHARMACOLOGIC INTERVENTIONS FOR AUTISTIC DISORDER

Drug	Findings
Serotonergic Agents	
fluvoxamine (Luvox)	Decreased restricted, repetitive behaviors; rigidity
fluoxetine (Prozac)	Decreased restricted, repetitive behaviors; rigidity
clomipramine (Anafranil)	Mixed findings
fenfluramine (Pondimin)	Mixed findings
Beta Blocking Agents	
propranolol (Inderal)	Reduction in aggressive, impulsive and self-injurious behavior
nadolol (Corgard)	Reduction in aggressive, impulsive and self-injurious behavior
Noradrenergic Agent	
Clonidine (Catapres)	Moderately decreased hyperactivity and irritability)
Dopaminergic Agents	
haloperidol (Haldol) (antagonist)	Reduced hyperactivity, stereotypies, and impairment in speech/communication
pimozide (Orap) (antagonist)	Reduced hyperactivity, stereotypies, and impairment in speech/communication
bromocriptine (Parlodel) (agonist)	Decreased withdrawal, communication deficits, stereotypies
levadopa (Sinemet) (agonist)	No improvement in withdrawal, communication deficits, stereotypies
amphetamines (indirect agonist)	Exacerbate stereotypies and hyperactivity
Opioids	
naltrexone (ReVia) (agonist)	Increased pro-social behavior Decreased stereotypies, hyperactivity, inattention self-injurious behavior (mixed findings)

*Comorbid disorders, such as anxiety and depressive disorders, should be carefully assessed and treated.

*Caution should be used when interpreting findings due to methodological differences (e.g., double-blind placebo-controlled vs open treatment studies; differences among types of raters) and methodological limitations (e.g., concurrent use of other medications).

cording to the Schopler and Hennike,[91] "Concern for the availability of optimum individualized treatment depends on the answers to the following types of questions:

- **Are the special needs and problems of the clients adequately understood and taken into account in the program's structure and procedures?**
- **Are the characteristics of clients and of staff taken into account so as to form a viable social group?**
- **Are conditions developed that will attempt and maintain dedicated and appropriately trained staff?**
- **Are staff training needs studied and understood so that appropriate staff continuity is assured?**
- **Is evaluation research built into the program, so that effectiveness can be assessed and programs modified as needed?**
- **Are appropriate efforts made to disseminate the needs of client and program to the community to assure understanding, acceptance, and support?**

Counselors work together with family members to ensure that these issues are appropriately addressed so that effective long-term residential treatment planning can occur.

PHARMACOLOGIC TREATMENT

Pharmacologic agents which affect the serotonergic system have been investigated due to evidence implicating serotonergic dysfunction in autistic individuals. The most consistent findings to date suggest that selective serotonin reuptake inhibitors (SSRIs) **such as fluvoxamine** (Luvox)[94,95] **and fluoxetine** (Prozac)[96] **decrease the restricted, repetitive behaviors and the rigidity found in autistic adults.** Mixed findings have been noted in studies with a serotonin reuptake inhibitor, clomipramine (Anafranil)[97,98] and serotonin releaser/reuptake inhibitor, fenfluramine (Pondimin).[99,100]

Treatment with beta blockers (propranolol [Inderal] or nadolol [Corgard]), which block noradrenergic receptors and reduce overall noradrenergic transmission, yielded a reduction in aggressive, impulsive, and self-injurious behavior in an open treatment study of eight autistic adults, with improvement also found in socialization and speech.[101,102] **It should be noted that many of these patients were also receiving neuroleptic or mood-stabilizing drugs.** A reduction in chronic hyperarousal was thought to be associated with symptom improvement. Clonidine (Catapres), an alpha-2 noradrenergic agonist, moderately decreased hyperactivity and irritability in eight autistic boys according to parent and teacher ratings, but not clinician ratings, in a double-blind, placebo-controlled study.[103]

Dopamine antagonists have been found to reduce hyperactivity, stereotypies, and speech and communication impairment in autistic children as has been evidenced in several double-blind placebo-controlled treatment studies with haloperidol (Haldol)[104-107] and pimozide (Orap),[106] independent of the sedative effects of these medications. However, the undesirable side effects of neuroleptics preclude this class of medications as a mode of *preferred treatment.* Treatment with dopamine agonists have yielded mixed findings. **Whereas an open trial of bromocriptine (Parlodel) has shown decreased withdrawal, communication deficits, stereotypic and idiosyncratic responses to the environment treatment with levadopa (Sinemet) has not been found effective.[108,109] Amphetamines, an indirect dopamine agonist, were found to exacerbate stereotypes and hyperactivity in some children.[110]**

Opioid receptor antagonists, such as naltrexone, have been used to treat particular core symptoms found in autistic patients. Increased pro-social behavior[111-115] and decreased stereotypies,[111,112,115] hyperactivity, inattention,[111,113,115] and self-injurious behavior[114,115] have been found following treatment with naltrexone (ReVia), although improvement in self-injurious behavior has not been found in all studies.[116]

Comorbid disorders frequently found among autistic adolescents and adults, such as anxiety and depressive disorders, should be carefully assessed and treated accordingly.

Summary and Conclusions

Autistic Disorder is a chronic, neuropsychiatric disorder associated with a dimensional triad including: (*1*) impairment in social interaction; (*2*) disturbances in speech and communication; and (*3*) restricted/stereotyped patterns of behavior. The disorder occurs more frequently among males; however, it manifests more severely in females. Overall intelligence and communicative speech are associated with its outcome. Deficits in social interaction remain throughout a lifetime. Cognitive deficits found in clients with Autistic Disorder include those in general intellectual ability, language capacity, attentional set-shifting, abstract problem-solving, cognitive flexibility, socioemotional abilities, visual memory, motor planning, and "theory of mind." Structural and cellular abnormalities in the brain have been identified in autistic individuals. The most consistent findings suggest that abnormalities exist within the brainstem, cerebellum, midbrain, and frontal lobes. These abnormalities have been associated with deficits in socioemotional skills, sensory processing, information processing, motor planning, and attention. Serotonergic abnormalities have been linked to the repetitive and stereotyped behaviors, restricted interests, and rigidity associated with autism. A dysregulated opiate system has been linked to self-injurious behavior, decreased sensitivity to pain, stereotypies, attentional dysfunction, and social withdrawal, all of which may be associated with autistic disorder.

Medications which have demonstrated some effectiveness in treating these symptom profiles include serotonergic, noradrenergic, dopaminergic, beta-blocking agents, and opioids. The serotonergic agents fluvoxamine and fluoxetine have been found to decrease restricted, repetitive behavior and rigidity. Dopaminergic antagonists, haloperidol and pimozide, have been found to reduce hyperactivity and stereotypies. The noradrenergic agonist clonidine was found to moderately decrease hyperactivity and irritability. The beta-blockers propranolol and nadolol were effective in reducing aggressive, impulsive, and self-injurious behavior. An opioid agonist, naltrexone, demonstrated increased pro-social behavior, decreased stereotypies, hyperactivity, and inattention. However, findings were mixed regarding its effectiveness in reducing self-injurious behavior.

Treatment planning needs to be highly structured, assessment-based, comprehensive, individualized, and collaborative. Interventions should take a multi-faceted approach, taking into consideration the autistic client's age, level of functioning, diagnostic profile, treatment history, neurological status, need, family considerations, and community resources. A comprehensive understanding of these factors along with a cooperative effort among the autistic individual, the family, and the rehabilitation counselor will create individualized, realistic, and effective treatment planning. Nonpharmacological treatments and interventions include social skills training, behavioral treatments, family-centered therapy, educational training, vocational rehabilitation, individual and group therapy, communication therapy, and residential treatment. The relevance of a particular treatment modality should be based on each individual's comprehensive profile.

A combination of treatments are often employed to best meet the needs of the client. For example, a 22-year-old, depressed, high-functioning autistic client may be best treated by combining efforts of a variety of treatment providers, including: (*1*) a rehabilitation counselor for overall case management, individual/family-centered therapy, and vocational rehabilitation, (*2*) a neuropsychologist for a comprehensive assessment, (*3*) a psychiatrist for medication treatment, and (*4*) a counselor at a supervised apartment. The importance of working together with the family cannot be emphasized enough, since Autistic Disorder demands a variety of services throughout the course of one's life. Moreover, periodic reassessment is required to determine if treatment planning needs to be modified over time. Thus, *collaboration* and *integration* are the key elements of successful interventions and rehabilitation counseling with autistic clients and their families.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

37. Which one of the following is *not* one of the three core dimensions of autism?

A. Impairment in social interaction

B. Disturbances in speech and communication

C. Auditory hallucinations

D. Restricted stereotyped patterns of behavior

38. Which one of the following is *not* a common characteristic of autistism?

A. Decreased rote memory

B. Decreased general intelligence

C. Decreased cognitive flexibility

D. Decreased verbal comprehension

39. Which one of the following statements is not correct regarding effective pharmacologic treatments in autistic clients?

A. Bromocriptine is effective in decreasing withdrawal and communication deficits.

B. Fluoxetine is effective in decreasing restricted and repetitive behaviors.

C. Levadopa is effective in reducing withdrawn communication deficits in autistic clients.

D. Nadolol is effective in reducing aggressive and impulsive behaviors.

40. Which statement is most true about autistic individuals in a work setting?

A. Autistic clients do well in jobs that are repetitive and socially restricted.

B. The mobile crew model of supported employment requires a full-time job coach working closely with a group of autistic individuals toward job placement paid for by the employer.

C. The TEACCH approach to vocational rehabilitation includes a holistic approach to treatment.

D. The entrepreneurial model integrates a group of autistic and nonautistic individuals in the development of a business.

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Directions in Rehabilitation Counseling

Volume 9 Lesson 11

Life Care Planning: An Overview

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Introduction

Life care planning is synonymous with rehabilitation planning, and is designed to outline the needs of individuals throughout their lifetimes. Since originally published by Drs. Deutsch and Raffa in 1981,[1] the concept has gained wide acceptance in civil litigation. By 1985, the life care plan was introduced to the healthcare industry in the *Guide To Rehabilitation*[2] by Drs. Deutsch and Sawyer. It has become a valued addition to the rehabilitation industry in a variety of forums. This lesson will provide the reader with important information about this emerging industry by:

- Apprising the reader of some of the rehabilitation arenas in which life care planning is practiced.
- Identifying basic concepts and procedures associated with life care planning.
- Educating practitioners regarding some of the controversies associated with the healthcare industry.
- Offering basic information with regard to expanding the rehabilitation counselor's practice, particularly in the private sector.

Definitions and Basic Concepts

Life care planning can be defined as a procedure for assessing future care needs and related lifetime costs of of individuals with chronic and/or catastrophic disabilities. The method is designed to solicit information from appropriate medical and other professionals to comprehensively plan for the care of the individual. The life care plan is a living document and should be updated as needed to reflect current needs.[3]

Catastrophic cases are defined to include severe traumatic brain injury, spinal cord injury, amputation or multiple fractures, severe burns, premature birth, congenital anomalies, organ failures and transplants, and debilitating diseases such as cancer and AIDS. Also included as catastrophic cases are chronic disabling conditions such as diabetes, multiple sclerosis, stroke, and cardiac and severe pulmonary diseases.

Rehabilitation counselors plan for the medical care of clients with these disabilities throughout their careers. The difference between traditional practices and the life care planning approach is partially in the way the plan is developed as well as its components. For example, rehabilitation counselors who work for a State rehabilitation agency develop physical restoration plans that ignore recreation, and other services and costs not approved under federal and state guidelines.

Although the life care plan concept was designed, practiced, and published by rehabilitation counselors, the predominant group practicing this specialized service is nurses. However, there are occasional arguments about the requisite minimum qualifications. Some experts state that for pediatric cases, the planner should have a minimum of a PhD,[4] others insist that nurses are uniquely qualified.[5] In general, it is accepted that a qualified life care planner is a professional who has the necessary rehabilitation training and experience to accomplish the tasks required.[6] Among the occupations represented in catastrophic case management and life care planning are facility-based case managers and discharge planners, independent or insurance-based case managers, nurses, rehabilitation counselors, allied health professionals (occupational therapists, physical therapists, and speech and language therapists), and physicians. **All of those involved are expected to control costs for the payer as well as facilitate communication, cooperation, and coordination of services essential to the successful outcome of the process.** These professionals come from a wide variety of industries including:

- **Workers' compensation and related disability insurance programs.**
- **Health care insurance, including health maintenance organizations.**
- **Vaccine injury fund settlements.**
- **Trusts for children and adults with medical needs.**
- **Estate planning.**
- **Mediation, including divorce action.**
- **Personal injury litigation.**

In addition to the requisite education, other factors for determining a professional's qualifications include work experience, training and experience in life care planning, and appropriate certifications. Table 1, originally published for purchasers of the service, outlines more detailed information regarding suggested topics and issues.[8]

Life Care Plan Procedures

The life care plan itself provides support to the managed care process, workers' compensation, and other healthcare-related future care planning.[9] The plan is a dynamic document that should be updated and revised as the individual progresses from acute rehabilitation to long-term rehabilitation. It should also integrate the funding rules associated with the industry (e.g., workers' compensation, personal injury, et cetera). **The process of obtaining information for all life care plans must be consistent in methodology. The life care plan should be specific to the individual and not generalized according to the type of injury.**

Imperative to the development of the life care plan is the understanding of the medical aspects of disability. By developing a firm understanding of disability and its complexities, the life care planner can design a plan intended to prevent most medical complications before they occur. In this way, life care plans can be an effective form of preventive rehabilitation. A rehabilitation counselor with limited medical kno vledge should consult a nurse or other medical professional who is proficient in this area.

As a first step, the life care planner must request all medical records and consultations. If the individual is involved in litigation, depositions of healthcare professionals are often available. **If the information is un-**

clear, a confirmation of the diagnosis is essential. The client/family interview often takes place in a hospital or treatment facility. If the client resides at home, it is recommended that the interview take place in the residence rather than in a professional office so the counselor can assess the individual's needs. A thorough assessment usually requires several hours.

During the initial interview, information is obtained with respect to the client's pre-incident medical and social history, family history, present physical and emotional status, medical treatment, socioeconomic status, employment history, and long-term plans. One of the reasons for conducting the initial interview where the client resides is to inventory all medical supplies; equipment he or she utilizes. It is unlikely that the client can remember all of the drugs and supplies, and an on-site inventory is the most effective way to determine current needs.

Subsequent to the review of medical records and the client/family interview, the life care planner begins the process of identifying long-term care issues and options. The treatment team is usually consulted and is encouraged to take an active role in the development of the life care plan. The life care plan and the plan procedure checklist are effective tools for accomplishing these tasks. **The life care planner acts to coordinate and communicate information between the members of the treatment team and the client and his or her family.** Generally, the life care planner will be the author of the document, although many people, in-

Table 1
CHECKLIST FOR SELECTING A LIFE CARE PLANNER

Professional Qualifications

- Education including degrees and continuing education? If doctorate, was the university accredited?
- Work experience?
- Life care planning experience?
- Research knowledge and experience?
- Certifications or Licenses? Generally accepted rehabilitation certifications include CLCP (Certified Life Care Planner), CRC (Certified Rehabilitation Counselor), CDMS (Certified Disability Management Specialist), CVE (Certified Vocational Evaluator), CRRN (Certified Rehabilitation Registered Nurse), CCM (Certified Case Manager), Diplomat or Fellow ABVE (American Board of Vocational Experts).
- Forensic experience (if appropriate)? Familiar with the rules pertaining to experts? Have they testified? Do they have a list of cases in which they testified at deposition or trial for the previous four years? Plaintiff/Defense ratio?

Awareness of Life Care Planning

- Are they Board Certified life care planners?
- Have they completed courses offered by a noted program on life care planning (e.g., Rehabilitation Training Institute, Intellicus, University of Florida, NARPPS, et al.)
- Can they cite life care planning references?
- Do they know some of the professionals associated with life care planning publications and training?

Commitment to the Profession

- What professional and disability specific organization(s) do they belong to? (Are they "legitimate" or fringe organizations, such as a for-profit organization owned by an individual or group with little recognition?)
- Do they participate in professional development?
- Have they contributed their time and effort by volunteering services to clients in need, speaking at conferences, holding office with professional organizations, writing articles or books?
- Have they received awards, honors, peer recognition?

Industry Experience

- Workers' compensation or Federal Office of Workers' Compensation Programs?
- Personal injury?
- Social Security?
- State rehabilitation?
- Long shore workers?
- Jones Act?
- Federal Employees Liability Act (FELA)?
- Short-term and long-term disability?
- Specialize in a particular disability?

Establish Medical Foundation for Opinions Established

- Use established published checklists and forms?
- Routinely consult with a physician as part of the team?
- Include other health professionals as appropriate (e.g., OT, PT, SLT, RT, Audiology, Neuropsychology, etc.)?

Other

- What and how do they bill for their services? Do they charge different rates for interview, records review, deposition or trial?
- Do they have a current curriculum vita?
- Do they have a history of arrests or ethics complaints?

cluding the client, provide opinions and recommendations. The life care plan will identify who recommended which items, topics, and treatment areas consistent with appropriate reasonable care. It is important to note that there are cases when the client and/or the family are not accessible.

Once an initial life care plan is developed and agreed upon by all concerned parties, investigation into resources, costs, and availability of services begins. The process of identifying resources can be a long and arduous task, involving research into community and national resources.

After a complete and thorough investigation, the life care plan is presented to and reviewed by the client, his or her family, if they are accessible, and the treatment team. This document can provide the family and life care planners the opportunity to coordinate and execute effective care options with a clear understanding of the financial resources necessary for completing the plan (See Table 2 for a summary of procedures).

ELEMENTS OF THE LIFE CARE PLAN:

The completion of a life care plan requires a complete review of the individual's needs. An overview of the topics to be covered in the life care plan follows. Many professionals have designed their own formats with different sections included. The style and topics may vary according to clients' needs, as long as all pertinent topics and details are encompassed.

Projected Evaluations

This section is intended to cover *nonphysician* evaluations that will occur on a periodic basis. These may include physical, speech, recreational, occupational, or music therapy, dietary assessment, audiology, vision screening, and swallow studies.

Projected Therapeutic Modalities

After projected evaluations have been completed, recommendations for ongoing non-physician treatment will be offered. In most catastrophic injuries, it is common to include physical therapy, speech therapy, occupational therapy, family education, counseling, among other similar therapies.

Diagnostic Testing/Educational Assessment

Generally, people with catastrophic impairments will undergo a variety of diagnostic tests, including neuropsychological, psychological, vocational evaluation, and, in the case of children, psychoeducational testing. Evaluations often will occur at specific points in a client's rehabilitation; each should be identified by date and cost. For example, a child might undergo specific types of psychological testing at the beginning of elementary school, onset of puberty, beginning of high school, and entering employment.

Wheelchair Needs

This section includes information on the type and configuration of wheelchairs. For example, a tetraplegic (quadriplegic) often requires a power chair that reclines or tilts-in-space. The individual accesses and controls the wheelchair in a variety of ways, including joystick, sip and puff, head tilting, and voice control. The specifications will allow the rehabilitation counselor to estimate costs from a variety of vendors.

Wheelchair Accessories and Maintenance

Each wheelchair usually requires certain accessories such as lap tables, carrying bags, and other customized features. In addition, the wheelchair requires maintenance. Maintenance can be very expensive for frequently used power wheelchairs or inexpensive for those, power or mechanical, used only for back-up purposes.

Aids for Independent Function

Many individuals have restricted use of their bodies and require certain aids to achieve independence. A common example is the environmental control that allows the client to turn lights on and off, open and close doors, start and stop computers, or to run electrical appliances. Some less expensive adaptive aids may include reachers that allow an individual to grasp items on a shelf or on the floor without having to stand up or bend over.

Prosthetics and Orthotics

Amputees usually need prostheses which need replacement and ongoing maintenance. The cost for all of the items as well as the replacement schedule should be included in this section. Most clients with significant head or spinal cord injury will make use of braces or ankle/

Table 2
STEP-BY-STEP PROCEDURE FOR LIFE CARE PLANNING

1. **CASE INTAKE:** When you talked with the referral source, did you record the basic referral information? Were time frames discussed? Financial/billing agreement? Retainer received (if appropriate)? Arrange for information release?
2. **MEDICAL RECORDS:** Did you request a *complete* copy of the medical records? Nurses notes? Doctors orders? Ambulance report? Emergency room records? Consultants reports? Admission and discharge reports? Lab work, x-rays, etc?
3. **SUPPORTING DOCUMENTATION:** Are there depositions of the client, family, or treatment team that may be useful? "Day in the life of .." video tapes? Are vocational issues to be included in report? If so, school records (including test scores)? Vocational and employment records? Tax returns?
4. **INITIAL INTERVIEW ARRANGEMENTS:** Is the interview to be held at the client's residence? Have you arranged for all appropriate people to attend the initial interview (spouse, parents, siblings)? Did you allow 3 to 5 hours for the initial interview?
5. **INITIAL INTERVIEW MATERIALS:** Do you have the initial interview form for each topic to be covered? Supplemental form for pediatric cases (CP, TBI, SCI) as needed? Do you have: a copy of the life care plan checklist? Example plan to show the client? Copy of appropriate Life Care Plan step-by-step booklet? Camera or video camcorder to record living situation, medications, supplies, equipment? Other documentation useful for developing a plan?
6. **CONSULTING WITH THERAPEUTIC TEAM MEMBERS:** Have you consulted with and solicited treatment recommendations from appropriate therapeutic team members?
7. **PREPARING PRELIMINARY LIFE CARE PLAN OPINIONS:** Do you have information which can be used to project future care costs? What is the projected requency of service or treatment? Duration? Base cost? What is the source of the information? Who are the vendors?
8. **FILLING IN THE HOLES:** Do you need additional medical or other evaluations to complete the plan? Have you obtained approval from the referral source to retain services of additional sources? Have you composed a letter outlining the proper questions to assure you are soliciting the needed information?
9. **RESEARCHING COSTS AND SOURCES:** Have you contacted local sources for costs of treatment, medications, supplies, equipment? Do you have catalogs or flyers? For children, are there services that might be covered, in part, through the school system?
10. **FINALIZING THE LIFE CARE PLAN:** Did you confirm your projections with the client and/or family? Treatment team members? Can the economist project the costs based on the plan? Do you need to coordinate with a vocational expert?
11. **DISTRIBUTION:** Have you distributed the plan to all appropriate parties, including the client, referral source, attorney?

foot orthosis (AFO). These braces, when custom designed, are costly and can add up to a significant amount of money over an individual's lifetime.

Home Furnishing and Accessories

A client living at home often will need a specialty bed, portable ramps, and client lifts. In-home care will require a specific inventory of the client's needs at home.

Drug and Supply Needs

This section includes prescription and non-prescription drugs and supplies. For example, a spinal cord-injured individual will have a lifetime need for an expensive inventory of catheters, leg bags, anti-spasm medications, and other supplies. The cost of these materials can represent a major cost of care over a lifetime. Ventilator-dependent tetraplegics have an even greater need for a variety of drugs, supplies, and medical equipment.

Home Care vs. Facility Care

It is desirable for a client to live in the least restrictive situation possible. This alternative generally helps to improve the emotional status of the client as well as to reduce complications due to diseases from others in the facility. However, this may not be the most cost-effective alternative. Facility care generally cannot offer the attentiveness a custom designed home-care program can. On the other hand, some individuals are not capable of living at home or their needs exceed those which are available in a home environment. **The required level of care must be identified in the life care plan, as some individuals need only occasional home-care and others need 24-hour, extensive nursing care.**

Future Routine Medical Care

Routine medical care includes annual evaluations by specialists appropriate to the disability. For instance, in spinal cord injury cases the client may need a one-day annual evaluation that includes X-rays and lab work. Oth-

ers may need custom-organized annual evaluations that include dental care, urology, dermatology, physiatry, orthopedics, neurology, and others.

Transportation

Transportation needs vary from individual to individual. Some clients need little or no modification to their vehicles. Simply adding hand controls to their present vehicle may be sufficient. Other clients may need a custom designed van with lift and wheelchair tie downs.

Health and Strength Maintenance

Health and strength maintenance was titled *Recreation and Leisure Time Activities* in the original literature[2] and was designed to identify specialty recreation needs, adaptive games, and devices that will allow clients to be as active as possible and engage in therapeutic activities which are less expensive than hiring physical or occupational therapists. **Activity is very important to the physical and emotional well-being of a client.**[10]

Architectural Renovations

If the client is to be cared for at home, significant and comprehensive architectural renovations often will be required. For example, a spinal cord injured client will need ramps, preferably at two entries into the home. Hallways may need to be widened, the kitchen may require modification, fire or smoke detectors may be installed, specialized floor coverings may be installed, bathrooms may be enlarged, and equipment and attendant rooms may be added. Hablutzel and McMahon[11] published architectural renovation standards based on the Americans with Disability Act.

Potential Complications

Potential complications are not included in the total cost of the life care plan, presumably because effective life care planning will reduce potential complications as it provides the structure for quality care. On the other hand, it is important for people to understand what common complications are involved with a particular disability. In the case of the significantly brain injured, individuals often re-injure themselves due to poor balance or poor judgment. Individuals with spinal cord injuries often have skin problems, cardiovascular difficulty, and pulmonary diseases. Individuals on phenytoin (Dilantin), an anti-seizure medication, commonly have gum disease or other dental problems. Poor psychological adjustment to the disability may occur; this is often a direct result of poor environment, poor care, or inability to engage in meaningful activities.

Future Medical Care: Aggressive Treatment or Surgical Intervention

In special situations the client will be in need of aggressive care. Phrenic nerve implants for spinal cord injury, functional electrical stimulation programs, short-term inpatient "tune up," and cosmetic surgery are examples. Usually these services are occasional or have time-limited treatment expectations.

Orthopedic Equipment Needs

Some clients will need specific orthopedic equipment such as body support equipment, walkers, or standing tables. This is often termed "durable medical equipment."

Vocational/Educational Plan

The rehabilitation counselor may be uniquely able to address this topic because most life care planners are not trained to assess vocational potential. This section should include the cost of job coaching, vocational counseling, tuition/fees, books and supplies, rehabilitation technology, and/or specialized educational programs.

ASSESSING VOCATIONAL POTENTIAL AND EARNINGS CAPACITY

A unique service the rehabilitation counselor can offer to most life care planners is the ability to evaluate the client's vocational potential and earnings capacity.[12,13] The term *earning capacity* has special relevance in personal injury litigation. **In general, capacity for earning is that occupational level which a client can reasonably attain and hold.** Consider that a 17 year-old female who delivers papers is catastrophically impaired and is never able to work again. Clearly, the earnings from her paper delivery do not represent her capacity to earn. On the other hand, a 55-year-old union truck driver who has worked steadily in this position for many years may exhibit an earnings history that is consistent with his capacity. Considerations include whether the indi-

viduals are children or adults and, if adults, the industry for which they are best suited. For example, drywall hangers may have reached their earnings potential by the time they reach their 20s or early 30s. On the other hand, attorneys may not reach their potential until very late in their career.

The information about income earnings capacity can be displayed in a variety of ways depending on the client. **In pediatric cases, particularly those with no educational history, it may be important to consider the job categories that are closely related to family trends.** It can be as specific as a job title if the family trends are very clear or general job categories as listed in census codes or broad classes of occupations. For an example, if a parent is a tractor-trailer truck driver, the child's earning potential can be determined based on a broad classification of jobs that require driving as the primary essential function.

Another useful strategy for pediatric cases is the expected educational potential that the client could have expected to achieve prior to injury compared with the post-injury educational level. For example, an individual who could reasonably achieve a college education prior to injury and now can reasonably achieve a technical education can have an earnings capacity based on the economist's projections on data that are available from government publications.

Computer programs that assess the client's worker traits (physical demands, environmental condition capabilities, educational levels, aptitudes, interests, and temperament) **may be utilized. The life care planner then searches government databases for job titles to determine likely occupations that a person with those worker traits could achieve.**[14] The counselor can compare pre-injury and post-injury capabilities to determine the median weekly wages for those categories based on Bureau of Labor statistics and census data. This approach is useful when there is corroborating information to justify the computer approach. Counselors should be advised that when one compares pre- and post-injury median weekly wages, the client's injury could potentially appear to *increase* the individual's earnings capacity because the post-injury median weekly wage average could be higher than the pre-injury wage average. This is easily explained because the likely jobs that a client will be precluded from performing post-injury are those which require more physical capability. Physically demanding jobs generally pay less than jobs that require more mental concentration. The earnings capacity, however, indicates the client should be able to achieve and maintain occupations which are appropriate to his or her worker traits.

Assessing a client's vocational potential based on his or her worker traits is very similar to the transferability of skills approach. The transferability of skills extends beyond the transferability of worker traits. Generally, an individual's worker skills are based on what he or she learn by doing. For example, an individual may have the potential to be a proficient typist, but he or she has not yet developed the skill. The following are ways to assess vocational potential:

- **Utilize work fields, which are the work methods and tools that one uses in order to accomplish various work tasks. "Work Fields" is a publication of this method.**[15]
- **Utilize the Materials, Products, Subject Matter, and Services** (MPSMS), **a government arrangement.**
- **Use the Data, People, and Things sections of *Dictionary of Occupational Titles*.**[16] **All job titles are assessed on different levels for each of these three categories and cross-referenced to other job titles that relate to the same arrangement. The Federal government is currently developing a new occupational database, O-NET98, which substantially adds to and revises the structure of analysis and the descriptive categories used.**
- **Use census codes, which are arranged in more than 500 different categories with job titles summarized into these categories. Cross-reference this census data with wage data from the Bureau of Labor Statistics. This provides median weekly wages for a variety of jobs within the same census code.**
- **Determine reasonable vocational opportunities for clients, taking into account access to the labor market and placeability factors.**

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Table 3
LIFE CARE PLANNING QUESTIONS REGARDING VOCATIONAL NEEDS

Have you determined whether any steps of vocational assessment have been considered or are already underway (e.g., already initiated by insurance company or attorney)?

What interview information have you obtained from the client (e.g., work skills, work history, leisure activities, education, functional ability)?

Have you obtained copies of relevant medical records?

Have you obtained work related information (e.g., tax returns, job evaluations, school and test records, training history, and treating or consulting MD comments)?

Does the client need testing before determining vocational potential (e.g., vocational evaluation, psychological, neuropsychological or physical capacities testing)? ***Also, is the evaluation a high quality, valid appraisal?***

If the client has work potential, is there a need for justifying a plan by performing a Labor Market Survey? If yes, what method is used (e.g., direct contact with employers vs. statistics or publications)?

What is the client's expected income including benefits? If personal injury litigation is involved, this includes pre- vs. post-injury capacity.

If there is an apparent market for the client's labor, is there a need for a job analysis? And if an analysis was completed, was it done according to the Americans with Disabilities Act guidelines?

What are the estimated costs of the vocational plan?

Are counseling or career guidance necessary? When does it start and stop? What is the frequency and cost (e.g., 30 hours over six months at $65/hr)?

Are there job placement, job coaching, or supported employment costs?

Are there costs for tuition or training, books, and supplies? Include dates for expected costs (e.g., technical training two years at $400/yr. for 1997-1999).

Are there needs for rehabilitation or assistive technology, accommodations, aids, costs for work, education, and/or training (e.g., computer, printer, work station, tools, tape recorder, attendant care, transportation)? ***Include costs and replacement schedules.***

What effect, if any, does the injury have on work-life expectancy? (e.g., delayed entry into work force, less than full-time, earlier retirement, expected increased turnover, or time off for medical follow-up or treatment)

Identifying the client's access to the labor market illustrates the loss of choice one experiences when a serious disability impairs functioning. It takes into account the number of jobs no longer available to the client. For example, an analysis of a client revealed that prior to injury, he or she had reasonable access to 50% of the labor market. After a serious injury, the client is unemployable. This would represent a personal loss of access to the labor market of 100%. **Although an individual may lose access to most occupations, he or she may not have lost the capacity to earn an income. Therefore, the primary issue is a client's placeability.** The labor market and economic conditions of the locale must be considered. A highly skilled client may live in a rural location where few opportunities exist for his or her labor activities, thus rendering client her incapable of earning a living. On the other hand, a client may appear seriously vocationally impaired but live in a metropolitan area with multiple opportunities and support services.

In order to complete the earnings capacity evaluation, an opinion about the client's expected work-life expectancy is required. An individual who has a reduced life expectancy usually will be expected to have a reduced work-life expectancy. If an individual can be expected to work six hours per day rather than eight, this represents a 25% loss of normal work-life expectancy. Other issues may include the extra time it takes for the person with a disability to find suitable employment; time off for medical treatment; longer time between jobs; and earlier retirement. For a summary of relevant vocational questions for the life care planner, see Table 3.

For rehabilitation counselors who choose to work in this specialized area, a mnemonic checklist intended to assure relevant data are included, particularly for personal injury litigation cases, is outlined in Table 4.[15]

Working With the Economist

In most situations the life care planner, particularly those who offer personal injury expert opinions, will work with an economist. **The economist uses the base costs in the life care plan to project the cost of care throughout the client's life expectancy.** The rehabilitation counselor who does not have an education in economic forecasting should not project life care plan costs in personal injury litigation cases. It is important to note that different rates of inflation are used for medical and non-medical care, as well as for the discounts to arrive at the present values of each item. On the other hand, there are a few states that endorse the "Alaska Rule" which assumes that inflation and reasonable investment rates are essen-

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tially equal and therefore no economist is needed. **However, it is strongly recommended that the life care planner consult with an economist for the ultimate cost of the life care plan, unless he or she is qualified to render opinions of damages to earnings and the costs of rehabilitation services.**

In order for an economist to project the cost of care, certain details must be included. Many healthcare providers offer opinions that a client will require follow-up services for a significant time. It is not possible to identify specific costs in these situations. **In order to obtain a bottom–line cost for the plan, the professional must include: (*a*) intended expected type and amount of treatment; (*b*) the date to start treatment; (*c*) the date to stop treatment; and (*d*) the base cost of treatment.** See Table 5 for an example entry that contains the minimum required data.

Identifying the frequency and duration of activities can be very complex. Pediatric catastrophic cases will include needs for periodic speech, occupational, and physical therapy which may begin and end at specific developmental periods in the child's life. For instance, occupational therapy may be needed for activities of daily living for a six-year-old client and may be discontinued until the child is ready to enter the workforce. At that time, an occupational therapist may rejoin the client's treatment team in order to furnish assistive devices for work-related activity. Treatment team professionals may fail to consider lifetime needs because they are most often involved in care lasting only one to two years.

Ethical Issues

The efficacy and value of the life care plan is dependent in large part on the ethics of the author. Several common issues that arise in this domain deserve brief mention.

PROFESSIONAL PREPARATION:

The qualifications of professional rehabilitation practitioners depend on experience and academic preparation. **It is imperative that one's credentials be represented accurately and that current licensure and/or credentialing be maintained.** Life care planning practitioners are held to the ethical standards of their professional discipline(s).

Table 4
THE RAPEL METHOD—A COMMON SENSE APPROACH TO FUTURE CARE AND EARNINGS CAPACITY ANALYSIS

Rehabilitation Plan

Determine the rehabilitation plan based on the client's vocational and functional limitations, vocational strengths, emotional functioning, and cognitive capabilities. This may include testing, counseling, training fees, rehab technology, job analysis, job coaching, placement, and other needs for increasing employment potential. Also consider reasonable accommodation. A life care plan is appropriate for catastrophic injuries.

Access to the Labor Market

Determine the client's access to the labor market. Methods include the LMA92 computer program, transferability of skills (or worker trait) analysis, disability statistics, and experience. This may also represent the client's loss of choice and is particularly relevant if earnings potential is based on very few positions.

Placeability

This represents the likelihood that the client could be successfully placed in a job. Consider the employment statistics for people with disabilities, employment data for the specific medical condition (if available), economic situation of the community (may include a labor market survey), and availability (not just existence) of jobs in chosen occupations. Note that the client's attitude, personality, and other factors will influence the ultimate outcome.

Earnings Capacity

Based on the above, what is the pre-incident capacity to earn compared to the post-incident capacity to earn? Methods include analysis of the specific job titles or class of jobs that a person could have engaged in pre- vs. post-incident, the ability to be educated (sometimes useful for people with acquired brain injury), family history for pediatric injuries, and LMA92 computer analysis based on the individual's worker traits. Special consideration applies to children, people with limited or no work history, people who choose to work below their capacity, and those with military training.

Labor Force Participation

This represents the client's work life expectancy. Determine the amount of time that is lost, if any, from the labor force as a result of the disability. Issues include longer time to find employment, part-time vs. full-time employment, medical treatment or follow up, earlier retirement, etc. Display data using specific dates or percentages. For example, the capacity for an average of four hours a day of work may represent a 50% loss.

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WHO IS THE CLIENT?:

For the purposes of this article, the client is the person

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Table 5
SAMPLE OF MINIMUM INFORMATION NEEDED FOR ECONOMIST TO PROJECT COSTS

Psychological Evaluation 6/98 at a cost of $600.
Expect counseling to start 7/98, one time per week, one hour session each for 26 weeks at a cost of $100 per hour.
Expect group counseling one time per week for 2 years, beginning 1/99 at a cost of $40 per session.
Expect medical follow-up four times per year by psychiatrist at a cost of $150 for the initial visit then $75 each visit until 1/00.
Medication prescribed is Prozac, 20 mg per day, from 7/98-1/00, at a cost of $60 for 30 pills.

Case Vignette

Reportedly, the client was pulling on a chain when the counter to which the chain was attached fell on him. The mother states the counter weighed between 200–300 pounds and required two men to pull it off of him. According to the medical records, the client was unconscious and had blood coming from his ears, mouth, and nose. He was diagnosed with severe closed head injury with multiple skull fractures and facial lacerations. The life care plan was complied in conjunction with the entire medical team and the developmental psychologist hired by the family.

Re: Sam Pull
Address: XXXX, Pittsburgh, PA XXXXX
Date of Report 5/6/93
Date of Birth: 4/11/89
Date of Injury: 11/11/91

REHABILITATION PLAN

ANTICIPATED LENGTH OF REHABILITATION PROGRAM: Through childhood and potentially lifetime follow-up.

Recommendation	Dates	Frequency	Expected Cost
Comprehensive Neuropsychological Evaluation	1994 (age 5) through 2007	1 X 1994, then yearly through 2000 (age 11), 2003, 2007 (age 18)	$600 (1994) then $1,000 each
Psychological Assistance			
a.Individual or couples therapy	1993–1995	Expect 1x/wk. for 6–8 mos.	$90–$110/hr.
b.Family and individual counseling	Begin 1995	1x/wk. for one year 2x/wk. from age 12–14 2x/wk. from age 16–18 1x/wk. from age 18–21	$90–$110/hr.
Physiatry Evaluation	1993–2007	Yearly	$75–$100 each
Occupational Therapy	To 1994 (age 5)	1–2x/wk.	$100 each visit
Physical Therapy Evaluation	Est. September, 1993	1x only (also see comprehensive eval.)	$100
Neurological Evaluation	1993–2001	Yearly	$80 each(not including EEG or CT scans or other diagnostic studies, if needed)
Ophthalmologic Evaluation for Strabismus	June 1993 to life expectancy	Yearly	$35–$55 each (does not include dilation or corrective lenses, if necessary)
Speech/Language Evaluation	1993 and 1994 at age 5 (included in comprehensive evaluation)	1x in 1993, 1994	$100 (1993) 1994 cost included in comp. eval.
Comprehensive Team (include medical, PT, OT, speech/language, etc.)	1994 (age 5)	1x only	$1800
Special Education			
a. Option 1: Private school for children w/disabilities. Also consider summer education or camp.	1993–2007 (Private school recommended by developmental psychologist)	36 wks./yr. (40 wks./yr., if summer school)	$10,000 per school year (recommended for maximum outcome) 4 weeks @$350–$1000/wk (summer)
b. Option 2: Public school system covered by the Individuals with Disabilities Education Act (IDEA). Include 13 years of learning disability consulting, 3x/wk. for school year and summer school.			$0 for public school. $40/hr. learning disability consulting, 36 wks./yr. regular school or 40 wks./yr. with summer school.
Neurobehavior Development Consultant	1993–2007	3 contacts w/school and client per year to enhance educational achievement	Expect 2 hours per occasion at $100/hr. (total 6 hrs./yr.)

Table 5 *(continued)*

Recommendation	Dates	Frequency	Expected Cost
Health & Strength Maintenance	1993 through entrance into school, 1994 (age 5)		No additional expected cost.
Driving Evaluation	2004 (age 15)	1x only	$400.
Vocational			
a. Pre-vocational evaluation	2005 (age 16)	1x only	$600.
b. Vocational evaluation	2007 (age 18)	1x only	$600
c. Vocational counseling, guidance, placemen assistance, and follow-up. (Costs for job coaching and supported employment, which may be appropriate, are not included)	2006–2009	150 hours over 3 years	$65/hr.
d. Post-high school education or vocational-technical training			Unknown

Note: This plan does not include costs associated with Mrs. Pull's case management services, nor her reduced ability to work outside of the home.

Potential Complications

These include, but are not limited to:
(1) Seizure disorder. (2) Risk of re-injury due to reduced judgment, intelligence, physical skills, and visual perception.
(3) More significant psychological reaction to injury than expected. (4) Poorer educational/vocational achievement than expected.
(5) Medical treatment and follow-up which is more extensive than expected.

Vocational Considerations of Access to the Labor Market

The limitations listed below are consistent with the U. S. Department of Labor definitions:

Physical Demands

Jobs which require significant amounts of functioning in following categories:

Standing/ Balancing
Reaching upward
Crouching
Sitting
Eye/hand/foot coordination
Operating controls with right hand/arm or right foot/leg
Stooping
Fingering
Visual perception

Cognitive Considerations

Significant visual-spatial perception disturbance
Reduced frustration tolerance
Slowed thought process
Distractibility
Reduced ability to be educated/trained (auditory learning recommended)
Problems with attention, concentration, memory
Difficulties following through on tasks
Trouble following directions
Reduced intelligence

Emotional

No current significant emotional difficulties noted. Expect moderate emotional difficulties upon entrance into formal education program (1994, age 5) and through various developmental periods to adulthood.

Conclusion

The client has experienced a mild to moderate impact on the range of job alternatives available to him. The client has reduced ability to be educated or trained. His loss of access to the *competitive* labor market is expected to be in excess of 98%.

Placeability

The client has experienced an impact on his ability to be placed in a job. Cognitive retraining and special educational services will be needed. Additionally, guidance/career counseling, job skills training, and selective placement is expected to decrease the impact of the injury on the client's ability to be placed in the *competitive* labor market. Job placement will depend to a large extent on the success of the client's rehabilitation program and his ability to complete a minimum of a high school education. Employment should maximize the client's strength in auditory skills.

Earning Capacity

PRE-INCIDENT—A review of the client's family history suggests the capacity for college education or master's level education. Earnings potential to be determined by economist.

POST-INCIDENT—High school or its equivalent and possibly technical school training. Earnings potential to be determined by economist.
Diminution of earnings capacity should be computed by an economist as well.

LABOR FORCE PARTICIPATION (Work Life Expectancy)—Although clearly not employable in the manner as before the accident, the client will have no reduction in labor force participation assuming no complications and an excellent rehabilitation/education program. Expect entry into labor force at age 20 (2009).

with a disability. It is important that the contract for services clarifies the responsibilities of the life care planner. The professional should provide objective, independent opinions limited to his or her field of expertise, and should demonstrate no conflict of interest. **Ultimately, the goal is to provide for the needs of the client over the life span in a manner that preserves quality of life and also remains cost-effective.**

INFORMED CONSENT:

In most cases, client consent is required for the review of confidential medical records, client interviews, and communication with providers of goods and services. The client must understand and consent to these services. He or she is free to withdraw consent from any or all portions of services at any time. In some cases, the life care planner may act as a consultant to an insurance company or attorney, in which case different rules may apply (e.g., workers' compensation, personal injury cases, or public sector rehabilitation).

CONFIDENTIALITY:

Protection of client confidentiality must be maintained within legal and ethical parameters at all times. Rehabilitation counselors and life care planners may release records of their work with proper authorization from the client or his or her legal representative. Written summaries and recommendations should be addressed to the referral source, and they can be responsible for distribution of copies to the client, insurers, and service providers. Special care should be taken with the use of computerized files, electronic mail, and facsimile transmission of information to ensure confidentiality.

LABOR MARKET SURVEYS:

It is common for rehabilitation counselors to conduct labor market surveys to develop opinions regarding a client's potential for employment and earnings capacity. The professional is urged to conduct these surveys based on written procedures and to solicit and record information objectively. The way in which questions are asked can bias the response; this may invite scrutiny if opinions diverge from what common sense would dictate.

WRITTEN REPORTS:

In personal injury litigation, it is not uncommon for rehabilitation counselors to decline to provide written opinions, probably at the request of the attorney who retained their services. Obviously, written reports represent the most common way of expressing opinions and making recommendations in all rehabilitation industries. Failure to do so in litigation-related cases is inviting criticism of the life care planning process as a whole. Also, with the advent of procedures in Federal and other jurisdictions, which grew out of the Daubert ruling,[17] technical information and procedures used to arrive at the expert's opinion are often required under provisions of "disclosure" to opposing counsel and the Court.

USE EXISTING STANDARDS:

In personal injury litigation, certain trends are developing with regard to how life care plans are compiled. In the past, some rehabilitation counselors have chosen to use their own private logic when outlining future care needs. Under the Daubert ruling,[17] the counselor must develop opinions subject to publication and peer-reviewed methods, procedures, and standards.

Conclusion

The emerging field of life care planning offers opportunity for rehabilitation counselors with an entrepreneurial spirit. The process can be used in a variety of healthcare settings and represents the state-of-the-art management of care of the seriously impaired client. When completed within the boundaries of published methodology, it is a valuable service which maximizes client care, reduces complications, and manages costs. Interested counselors are urged to obtain specific training in this specialty (e.g., One option is Intelicus, a partnership between the University of Florida and the Rehabilitation Training Institute. Call (800) 431-6687 for information.) and to seek national certification as a life care planner (Contact the Commission on Disability Examiner Certification at (804) 272-9192 for information).

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

41. According to the author, the life care planning procedure:

A. Is one which is followed only at a very early point in the medical recovery of a catastrophically impaired client.

B. Is one which has been utilized extensively by rehabilitation counselors who have worked for a State rehabilitation agency.

C. Is meant to assess future care needs and related lifetime costs of catastrophically impaired clients.

D. Is developed by a rehabilitation practitioner, independent of involvement with other medical and rehabilitation professionals.

42. Imperative to the development of the life care plan is:

A. Content which is generalized by the type of injury or impairment.

B. Maintaining flexibility in the methods used for gathering information.

C. A focus on current needs, rather than possible future needs or complications.

D. A full understanding of the medical aspects of the disability.

43. In addressing income earnings capacity, the life care planner can utilize a variety of ways to display the information depending on the client. For a pediatric case,

A. An economist's projections on data pertaining to educational achievement available from government publications might prove useful.

B. It would not prove beneficial to consider job categories that would be closely related to family trends, even if the individual had no work history.

C. A transferable skills analysis, in which a computerized program for the asessment of the client's worker traits and searching of government databases, would be a rehabilitation practitioner's preferred method of analysis and presentation.

D. The rehabilitation practitioner does not have to consider the locale's labor market or economic conditions.

44. The RAPEL Method for the analysis of future care and earnings capacity

A. Assumes that the client has lost no access to the local labor market due to the injury or impairinents they have acquired.

B. Considers the likelihood that the client could be successfully placed in a job.

C. Gives no special consideration to children, women with limited or no work history, people who choose to work below their capacity, and those who are trained in the military.

D. Assumes that all individuals will work until the reach the age for qualification for full Social Security retirement benefits.

Directions in Rehabilitation Counseling

Volume 9 Lesson 12

Preparing for Cross-Examination as an Expert Witness

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Introduction

In response to Federal civil rights legislation, the Americans with Disabilities Act, and state worker compensation statutes, an increasing number of rehabilitation professionals are being asked to serve as expert witnesses.[1-4] Rehabilitation counselors are a natural choice to inform courts regarding the complicated vocational and disability related issues involved in many civil suits. It has been noted that many individuals in the rehabilitation field are called upon to testify in legal procedings against their wishes.[5] Others view expert testimony as appropriate and desirable, and wish to serve effectively as expert witnesses. Often witnesses find trial procedures to be challenging and stressful. In recent years, many books and articles have been published for those wishing to learn about trial procedures and the role of expert witnesses.[6-8]

Without question, most witnesses regard cross-examination with apprehension. No other courtroom procedure is more challenging or potentialy unpleasant than the ordeal of being questioned and criticized by an experienced attorney.[9,10] With respect to rehabilitation counseling and related professions, it is likely that cross-examinations will become even more important in trails. Changes in the Federal Rules of Evidence have given courts wider discretion in determining what may be allowed as expert testimony. Formerly, courts used the standard that an expert's opinion had to represent the generally accepted view in the appropriate discipline. **Since the U.S. Supreme court decision in the Daubert v. Merrell Dow Pharmaceuticals case in 1993 federal, courts can now accept a wider range of expert testimony if it will help the court to understand evidence or determine a fact at issue.**[10,11] It is the responsibility of the judge to ensure that testimony is relevant and reliable. Although not bound by federal rules of evidence, it is possible that many states will follow this lead. **Opening the door to diverse expert views, in behavioral sciences already known for having few generally accepted theories, can be expected to make cross-examining attorneys even more vigorous in attacking questionable opinions.**

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The objectives of this lesson are to explain the function of cross-examination in trial procedure and to prepare rehabilitation professionals to recognize and counter the strategies and techniques used by lawyers to cross-examine expert witnesses.

Trial Preparation and Direct Examination

Witnesses provide three types of testimony: deposition, direct examination, and cross-examination.[12] **Depositions are sworn statements recorded prior to a trial that are included as evidence in the trail. Direct examination is testimony brought forth in court by the attorney who has called the witness to the stand. Cross-examination refers to questions presented by the opposing attorney that are intended to contradict or alter the original testimony of the witness.** Although the emphasis of this lesson is on cross-examination, the reader should also appreciate the related importance of trial preparation, deposition, and direct examination. A witness cannot effectively withstand cross-examination on the basis of direct testimony that is flawed or incomplete.[2,13] **The following considerations are essential to sound and comprehensive preparation for deposition and direct examination:**

1. **Undertake a complete review of all records pertinent to your testimony in the case. Refresh your memory concerning the historical events and important facts of the case. Obtain information verifying the validity and reliability of any tests that may have been used.**[13]

2. **Conduct a thorough literature review and identify authoritative sources that support your conclusions.** Also, be familiar with the literature that opposes your position. You should be prepared to describe differences of opinion and explain your rationale for favoring one position over another.[14]

3. **Update your curriculum vitae and highlight all relevant education, employment experience, credentials, professional memberships, and publications.** The court will wish to review your qualifications before deciding whether you can be admitted as an expert witness.[2,14]

4. **Attend a pretrial conference with the attorney who has retained you as an expert. The purpose of the conference is to review your role in the trial, not to memorize testimony.** The conference should clarify your role in the case and indicate what you can expect from the attorney who has retained you as well as from the opposing counsel.[15,16]

5. **Under direct examination, answer all questions as directly and completely as possible.** Avoid unusual terms and emphasize the key points in your testimony. Speak in a clear voice and look at the jury when answering questions.[3]

6. Remember that you will be held responsible at the trial for anything you say under oath at the deposition. **Never sign a deposition without first reviewing the transcript carefully for accuracy.**[7,17]

Cross-Examination in Trial Procedure

The American legal system uses an adversarial method of determining the truth. In practice, this means that courts consider the credibility of one interpretation of a set of facts against the credibility of another interpretation.[18] The interpretations of facts are advanced by attorneys who represent opposing sides. Cross-examination offers jurors an opportunity to assess the credibility of a witness and make judgments concerning the relative impact of the witness's testimony. In advancing a position, an attorney tries to minimize the impact of testimony that supports an opposing view of the case. For this reason, attorneys emphasize the importance of perfecting various approaches to cross-examination and preparing for specific cross-examinations in court.[18–20] **When cross-examining expert witnesses, attorneys tend to rely on three approaches: appropriating the testimony of the witness, impeaching the credibility of the testimony, and impeaching the credibility of the witness.**

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APPROPRIATING THE TESTIMONY OF THE WITNESS:

From an opposing attorney's point of view, the most effective possible result of cross-examination is to alter or appropriate an expert's testimony so that it supports the opposing attorney's interpretation of the facts. In a "constructive cross-examination," McElaney states, "you use the witness to develop facts favorable to you rather than trying to undercut what he has said on direct-examination."[21] Skilled attorneys know how to use this strategy, called appropriating the testimony of the witness of the other side. There are two standard approaches to appropriation of testimony.

One approach is to encourage the witness to agree with small parts of the cross-examiner's position. Sometimes this means persuading one expert to agree with selected aspects of an opposing view held by another expert. The cross-examiner may only wish to prepare the jury for the confusion of having to sort out the contradicting opinions of two experts. He or she may pose a question like the following:

> **Q. Dr. ____, could two social scientists, using the same or similar data, also use different theoretical models and arrive at different conclusions?**
>
> A. Yes, that happens.

By admitting to this aspect of the cross-examiner's case, the witness has reduced the aura of infallibility that surrounds experts in the minds of some jurors.

If the cross-examiner plans to present another expert witness, the questions will lead toward a more specific set of concessions.

> **Q. Dr. ____, vocational experts commonly use tests to obtain data, and that data becomes an important part of the basis for the experts' conclusions, isn't that right?**
>
> A. Yes.
>
> **Q. The standard practice is to use a variety of carefully selected tests, is that correct?**
>
> A. Yes, it is.

In the above example, the cross-examiner is establishing a basis for later arguing that his or her own expert used a wider or more carefully selected variety of tests and is therefore more credible than the opposing expert. It will strengthen the argument to say that even the other side's expert admitted to the importance of using various well-chosen tests.

In the second approach, attorneys use hypothetical questions to appropriate the testimony of an expert witness.[3,22,23] In trial procedure, experts are permitted to offer statements of opinion, interpretations of an assumed set of facts. The cross-examining attorney may ask the expert how an opinion would be affected if the facts differed. If the expert's response is unchanged, it will appear unreasonable or biased. If the expert concedes that the opinion would be altered if facts were different, the cross-examiner likely will attempt to show the existence of those other facts.

> **Q. Dr. ____, a moment ago you stated it is your opinion that ____ is qualified for employment as a customer service representative, is that right?**
>
> A. Yes, it is.
>
> **Q. What are the essential interpersonal qualities of a customer service representative?**
>
> A. I would say that a customer service representative needs to be outgoing, pleasant, calm, and helpful.
>
> **Q. Would sudden outbursts of temper be consistent with the profile of a customer service representative?**
>
> A. No, of course not.
>
> **Q. Then if you were aware that ____ was prone to such outbursts, it would change your opinion of this person's employment qualification, would it not?**
>
> A. I have no such knowledge about ____.
>
> Q. But if you did, would it change your opinion?
>
> A. That would change my opinion, yes.

One frequently used cross-examination technique involves leading the witness to a desired answer by asking a hypothetical question after a series of seemingly harmless questions.[24] Donovan suggests, "Throw

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a bad witness into a habit of a great many yeses to your questions till [he or she is] ready to say it snowed in July, if need be."[25] By using hypothetical questions, a cross-examiner can set the stage for the introduction of facts or conditions of which the witness was unaware.

IMPEACHING THE TESTIMONY OF THE WITNESS:

If an opposing attorney cannot appropriate the expert's testimony, then it is necessary to find a way to discredit that testimony and reduce its impact on the outcome of the trial. An attorney can use three types of questions to reduce the credibility of an expert's testimony: questions focusing on reference to known authorities, on prior inconsistent testimony, and on prior inconsistent statements.[11,26]

One way to neutralize the effect of expert testimony is to show that the expert's opinion is inconsistent with that of recognized authorities in the field, a tactic known as reference to known authorities.[27] If an expert's opinion differs from that of a respected authority, the expert will seem either uninformed or representative of a fringe element of opinion. First, the cross-examiner must get the witness to acknowledge the authority of the individual holding the opposite view:

Q. Are you familiar with Professor ____?

A. Yes.

Q. His book *Human Motivation* establishes him as an authority on the topic of attribution, doesn't it?

A. Yes.

Q. Do you also recognize him as an authority?

A. Yes.

Q. Now Dr. ____, you have testified that since his dismissal, _____ has experienced feelings of shame resulting from ability attributions, isn't that right?

A. Yes.

Q. And yet in his book Professor ____ stated that shame is linked to effort expenditure. How do you explain the difference in your position?

In order for this strategy to succeed, the cross-examiner must be careful to select opposing authorities who are distinguished experts with outstanding credentials and records of publication.

A cross-examiner may also discredit an expert's testimony by revealing internal inconsistencies within the testimony itself. This can have a dramatic effect, making the expert appear either confused or dishonest:

Q. Dr. ____, do you remember your deposition given on ...?

A. Yes, I do.

Q. You were under oath at the time, were you not?

A. Yes, I was.

Q. Dr. ____, you just said that you made an assessment of drug dependency based on a structured interview.

A. That's right.

Q. At the deposition you said you made your assessment on the basis of medical records. Were you lying at the deposition or are you lying today?

When accused of perjury, the witness may attempt to clarify what was meant at the deposition; he might argue that the assessment was based on the plaintiff's medical record as given in the interview. Although the question of dishonesty may recede, the appearance of vagueness and exaggeration will have done considerable damage to the expert's testimony.

A third method of impeaching the credibility of an expert witness's testimony involves contrasting it to prior published or recorded statements by the witness.[27] It is not uncommon for authors, particularly those who have written over a number of years, to forget certain statements they have made in the past; some have also changed points of view in keeping with the evolution of opinion in their fields. Skilled attorneys will obtain the publications of experts they intend to cross-examine and search them carefully for potentially damaging statements:

Q. Dr. ____, you are a published author, are you not?

A. I have written articles in my field, yes.

Q. In your 1992 article in the *Journal of* ___, you wrote "...." Do you recall writing those words?

A. Yes.

Q. In your testimony earlier today, you said "...." Isn't that so?

A. Yes.

Q. Can you explain why your testimony today is directly contrary to your published opinion?

The existence of inconsistent prior statements will tend to make the expert's opinions seem speculative and unreliable.

IMPEACHING THE CREDIBILITY OF THE WITNESS:

If an opposing attorney cannot appropriate the expert's testimony or reveal contradictions within that testimony, he or she can use a third strategy to decrease the expert's impact on the outcome of the trial: attempting to invalidate the expert's testimony by generally discrediting him or her. This tactic is the most dangerous approach available to the cross-examiner, because it may undermine the concept of expertise in the minds of the jury and reduce the impact of any experts the cross-examiner uses. Also, *ad hominem* attacks on the witness may backfire and create sympathy on the part of the jury. Nevertheless, an expert witness should expect such questions if other approaches to cross-examination have been ineffectual.

One method a cross-examiner can use to reduce experts' credibility is to show that they are biased, a predisposition to taking a certain point of view that makes them incapable of being impartial.[22,28,29] Many rehabilitation professionals give testimony in trails or administrative hearings on a regular basis.[30] Such work may take on a characteristic pattern of advocacy. For example, an expert may work exclusively for the same attorney or always testify on behalf of the plaintiff. Fees received for court-related work may be a significant part of a rehabilitation professional's financial income. The cross-examiner can use these points in various ways to inflict damage on a witness's credibility:

Q. Dr. ____, during the past year, how many times have you testified as an expert in cases involving employer liability?

A. About seven times.

Q. In each of those cases you were called as a witness by the attorney for the plaintiff, were you not?

A. Yes, that's true.

Q. And in each case you were paid for your time, weren't you?

A. Yes.

Q. What is your fee for your work on this case?

A. $100 per hour.

A cross-examiner may ask the witness to provide the court with names of scholars who hold views that are opposed to the witness's. If the witness is unable to provide such a list, he or she will appear slanted and uninformed.[3] The cross-examiner may also ask whether the witness participated in a pretrial conference with the opposing attorney, knowing that in most cases such a conference would have occurred. Asking about a pretrial conference implies that the witness has been instructed in what to say. It is important for the jury to understand that the occurance of pretrial conferences is customary and does not imply that the content of the expert's testimony has been fabricated.

Attorneys specializing in certain types of case law frequently face expert witnesses and may possess an impressive knowledge of an expert's field. The witness should not be surprised if the cross-examiner is aware that certain approaches are incomplete or considered outdated. Cross-examiners frequently question the validity and reliability of tests, attempting to reveal flaws in the expert's basis for opinion. If the witness is a professor at a college or university, the cross-examiner may attempt to show that the witness has limited or outdated practical experience in the field.

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Q. How long have you been a professor at the university?

A. Since January of 1986.

Q. When was the last time you actually conducted a job analysis?

A. That would have been in 1985.

Q. And when did the Americans With Disabilities Act go into effect?

A. In 1992.

In addition to the strategies described above, a number of tactics may be employed by the cross-examining attorney to unnerve the witness and contribute to impeachment of credibility. **The cross-examiner may present the witness with a sequence of questions concerning trivial details** (e.g., On what date were your hired by your present firm? How many other people work in your office?). Prepared with these questions in advance, the cross-examiner will pose them at a rapid-fire pace to confuse the witness.[19] **The purpose of such questions is to lead the witness into making a self-contradictory statement.**[27] **The cross-examiner may then ask why the jury should be expected to believe the witness on matters of critical importance if the witness isn't even certain of trivial matters.**

The cross-examiner may review the deposition for questions the witness had been unable to answer, and repeat each question on cross-examination. The purpose of such a review is to produce a series of "I don't know" answers from the witness, reducing the aura of expertise. An additional aim is to tempt the expert into answering questions on cross-examination that he or she had been unable to answer at the deposition, thus impeaching the testimony given.[21]

Cross-examiners may attempt to reduce the credibility of the witness by provoking a display of character flaws, such as condescension or bad temper. The expert may be frustrated with frequent requests to spell or define technical terms. The cross-examiner may affect a scolding tone of disapproval and contempt or feign astonishment at any statement the witness makes.[31-33]

Q. How many times did you interview Mr. Smith?

A. Once.

Q. You interviewed Mr. Smith once?!!

RECOMMENDATIONS:

Expert witnesses provide an essential service in the courtroom, that of informing the jury in areas of vital importance that might otherwise remain unclear. Unfortunately, the potential value of many experts is diminished by failures of preparation, disposition, and manners. It is in the cross-examiner's interest to bring out and exploit any weaknesses in the expert's testimony or personality. The following recommendations will help expert witnesses respond effectively to cross-examination and preserve the integrity of testimony:[34]

1. **Expect to be asked hypothetical questions regarding conditions under which you would change your opinion. In preparing to testify, note in advance what essential facts would need to be different before you would alter your opinion. Avoid the appearance of being stubborn in refusing to modify conclusions. However, do not be afraid to let the jury know that certain facts would need to be significantly different before your opinion would change.**[18,35]

2. **When answering questions, respond clearly and completely, and avoid using generalities** (e.g., always, every, never). **Answer questions as accurately as you can and do not exaggerate or minimize details. If you do not know or remember the answer to a question, say so; do not guess at an answer or avoid the question.**[36,37] **The cross-examiner may try to confuse you by asking questions rapidly. Don't answer a question until you have taken sufficient time to think about your answer.**[38,39] **If you did not hear or understand a question, or if you need time to formulate an answer to a lengthy or complicated question, ask that it be repeated or clarified before you attempt to answer. The cross-examiner may repeat a question several times in slightly modified forms, hoping you will contra-**

dict yourself. State that you have answered the question to the best of your ability.

3. **Stay calm and deliberate in your response to questions.** If the cross-examiner stands over you in an intimidating posture, request that the judge instruct the cross-examiner to stand away.[29] The cross-examiner may present questions in harsh or disbelieving tones intended to unsettle or anger you.[32] **Always remain courteous.** Keep in mind that you, the expert, possess knowledge important to the case.[30] Often, a jury will have to consider the opinions of conflicting experts. The jury will usually be influenced most by the expert who maintained the steadiest response to cross-examination.

4. **Expect the cross-examiner to use deceptive tactics.** Some questions may imply conditions that are not accurate. For example, a cross-examiner may ask, "How much are you being paid for your opinion?" The question indirectly suggests that the expert is being paid to give a specific opinion rather than being reimbursed for professional time. **If the cross-examiner asks a question that subtly alters testimony you have given, or puts words in your mouth that are not yours, point out the discrepancy.** If the cross-examiner uses an obscure term with which you are not familiar, don't attempt to bluff. Ask for a definition of the term. Don't answer non-questions. The cross-examiner may make a statement such as, "That seems a bit far-fetched." Do not add information until a question is posed. Rutledge points out that you can respond, "If that is a question, I don't understand what the question is."[33]

5. Avoid the use of certain common witness strategies.[9] **Do not try to counter a difficult question with discipline-specific jargon.** The jury may interpret jargon as a sign of arrogance. Do not counterattack when the cross-examiner seems vulnerable. Debating with the cross-examiner may open new areas of inquiry for which your attorney is not prepared. **Resist the temptation to be witty or humorous.** Such opportunities may be an ambush. Remember that cross-examiners are experienced advocates capable of handling the most clever of witnesses.

6. **A cross-examiner may elicit statements from you that are damaging to your attorney's case. Stay relaxed. Remember that your attorney will have the opportunity to restore your testimony by re-direct examination.**[9] It will help your testimony to remain calm and focused on your answers.

Summary

Increasing numbers of rehabilitation counselors and educators are being asked to give expert testimony in legal proceedings. Cases involving personal injury, regulatory compliance, and even divorce frequently require the specialized expertise of vocational rehabilitation professionals to inform the court. The impact of an expert's testimony on the outcome of a trial hinges on the extent of preparation and competence of that witness.

Cross-examination is a vital part of the judicial process and is usually regarded as the most unpleasant. In this lesson we have reviewed the purpose of, and major approaches to, the cross-examination of expert witnessess. The cross-examiner will usually try one or more of three basic approaches to reduce or eliminate the impact of an expert's testimony. The cross-examiner will, if possible, attempt to use the expert's testimony to support the cross-examiner's theory of the case. If appropriation of the expert's testimony is not possible, the cross-examiner may either impeach the specific testimony of the expert or cast doubt upon the credibility of the expert as a witness in general.

Expert testimony is often a decisive factor in the outcome of a trial. In order to function effectively as witnesses, rehabilitation professionals must be knowledgeable about and prepared for the complexities of cross-examination.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

45. Cross-examination refers to questions presented by the:

A. Attorney who has called the witness to the stand

B. Opposing attorney in order to contradict or alter the original testimony of the witness

C. Opposing attorney, directed to the witness during a deposition

D. Opposing attorney, which have more to do with the witnesses qualifications than the facts or opinions that have been presented

46. Sound and comprehensive preparation for deposition and direct examination:

A. Does not include a review of relevant literature or authoritative resources that may be supportive of the witnesses testimony

B. Includes a pre-trial conference with the retaining attorneys in order to review the exact answers to the questions that will be posed and adjusting them to fit the hypotheses being presented by the attorney

C. Does not require the witness to be familiar with historical events or all major facts of the case, nor the validity or reliability of tests that may have been administered

D. Includes an updating of the witness' qualifications as an expert witness, such as his or her curriculum vitae

47. Within a cross-examination, a skilled opposing attorney will often:

A. Attempt to impeach the credibility of the expert witness as the initial approach to challenging the testimony

B. Attempt to appropriate the expert's testimony, in order to develop facts that would be favorable to their own hypotheses or views

C. Attempt to reduce the credibility of the expert witness, as this is a relatively safe approach that would not likely hurt their own presentation of the case

D. Show total disregard for the expert's testimony and will show the court why it is of no value in the current case or similar cases

48. An appropriate response of an expert witness, when being cross-examined, would be to:

A. Use discipline-specific technical terminology and jargon

B. Point out a discrepancy in a question that the opposing attorney has posed to subtly alter the testimony that the expert had previously given

C. Feel free to verbally attack the opposing attomey if he or she had resorted to treating the expert witness in an abusive or condescending manner

D. Becoming witty or humorous in order to lighten-up the proceedings

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